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The MODERN HOSPITAL

Vol. XXVI

April 1926

No. 4

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXVI

April 1926

No. 4

THE FUTURE PROGRESS OF MEDICINE*

By Alexis Carrel, M.D., Rockefeller Institute,
New York

IT APPEARS particularly appropriate, I believe, to speak of the progress of medicine in this hospital where for many years the clinical divisions and the laboratories have worked together for the greatest benefit of the patients and also for the advancement of medical knowledge, that is, for the good of the future patients. We must always realize that the only purpose of medicine is to decrease human suffering by preventing disease or curing it. But this end cannot be reached except through a scientific understanding of the functions of the organism when modified by pathogenic factors.

Today, medicine consists of an immense quantity of observations, partly empirical and partly classified according to scientific method. It is a science in the making. While the treatment of certain diseases, for instance, the disturbances of the pancreas and the thyroid gland, is thoroughly scientific, the handling of

others, such as mental diseases, is still empirical. It is obvious that the progress of medicine is bound to the development of the sciences concerned with living matter and living organisms.

What Science Must Accomplish

THE progress of medicine is the most important factor in the development of civilization. We ask from medicine the solution of the problems that are vital to the greatness and happiness of the human race.

The purpose of medicine is to decrease human suffering by preventing disease or curing it. But this end cannot be reached except through a scientific understanding of the functions of the organism when modified by pathogenic factors.

Scientifically organized hospitals and institutes for medical research, by merely continuing the investigations in which they are at present engaged, will immensely advance our knowledge of the nature and mechanism of disease. But fundamental principles have to be discovered; entirely new fields must be opened, and this can be accomplished only by pure science.

These sciences, which deal with intricate physicochemical phenomena and meet with immense technical difficulties, have advanced much more slowly than those that concern themselves with non-living matter and occupy a lower rank in the hierarchy of knowledge. Physiology, which was in its infancy when physics and chemistry were widely developed, cannot as yet supply to medicine in every part of its field the information necessary for the scientific study of its problems. As the physician must help patients afflicted with all kinds of disease, he cannot always remain in the territory

which has been scientifically explored. Therefore, his task is very much more difficult than that of the physiologist who can select his problem, reduce it to its simpler terms, and solve it by techniques accurately adapted to the subject

*Address delivered before the annual meeting of the board of directors of Mount Sinai Hospital, New York, by Dr. Carrel.

of the experiments. On the contrary, the physician must wander through the entire field of medicine and often meet with diseases due to unknown causes and developing within an organism of unknown resistance. He is helped by his scientific knowledge as far as it goes. But when he has reached its limit, he has to guess. The great clinician must possess the intuitive power of the man of genius.

Fifty Years of Triumph

The past fifty years have been a period of triumph for medicine because the revelation by Pasteur of the rôle of microorganisms in disease has led to the creation of bacteriology and immunity. These sciences have brought about in a spectacular way the conquest of infectious diseases, a fact of momentous importance to humanity. The death rate of the population of civilized countries has been decreased by better hygiene and efficient protection against cholera, plague, yellow fever, and also typhoid and tuberculosis.

Not only has preventive medicine determined an increase in the quantity of human beings, but it has allowed profound modifications in their mode of living. Men are crowded into large cities and into factories where they work as part of the machines, without danger of great epidemics, and without seriously impairing their health. Immense armies, which heretofore would have been rapidly reduced in size by infectious diseases, are kept in the field for years without large spontaneous losses. The admirable work of Gorgas in Panama has opened a new era in the history of mankind. Life in the tropical climates has been made possible for the white man who has thus acquired the power to dominate the entire world. While the ultimate significance of Pasteur's discoveries cannot be foreseen, it is certain that medicine, in protecting men from infectious diseases, has already made miraculous progress.

What Are the Benefits?

But we may doubt whether this victory has so far brought much happiness to the world. Has it greatly modified the position of the average man as regards disease and death? Probably not. Although the adult individual has much fewer chances of dying from smallpox, cholera, tuberculosis or typhoid fever than fifty years ago, his expectation of reaching the age of seventy-five or eighty has not markedly increased. But he surely has more prospect of being tortured by some form of cancer, afflicted with slow diseases of the kidneys, the circulatory apparatus, the endocrine glands, of becoming insane, suffering from nervous diseases, or of making himself miserable by

his lack of judgment and his vices. Modern medicine protects him against infections that kill rapidly but leaves him exposed to the slower and more cruel diseases and to brain deterioration.

There is no great hope of immediate improvement in this situation, in spite of the remarkable advances that have been made recently in physiology by the discovery of the active principles secreted by endocrine glands, by the building up of the science of nutrition, and by a better conception of respiration, of metabolism, of the acid-base equilibrium of the blood. Although great progress has been accomplished in the treatment of diabetes and of the disturbances of the thyroid gland, it is far from possible to cure these diseases or prevent their occurrence, as we are still absolutely ignorant of their causation.

The insufficiency of medicine is more flagrant when it deals with tumors. What are the determining factors of cancer? What is its nature? What are the causes that render the human organism susceptible to malignant tumors? No one today can give a scientific answer to these questions. We do not know what brings about arterial hypertension. Our ignorance of the causes of chronic nephritis and of most of the diseases of the circulatory apparatus is practically complete. It is neither possible to cure nor to prevent them. Our lack of knowledge is still greater in the field of the nervous and chiefly of the mental diseases whose nature remains almost as mysterious as it was during the Middle Ages.

Future Progress of Medicine

It is clear that the future progress of medicine must consist in finding the nature and causation of some of these diseases and their prevention. Medicine should attempt to lead men to extreme old age without suffering, and also to increase their moral and intellectual value, because the quality of the individuals is far more important than their quantity for the happiness and progress of the community. To expect this from medicine does not appear to be asking the impossible when we consider what has already been accomplished.

If our civilization does not crumble, and if scientific research goes on at increased speed, we can reasonably believe that our expectations will be fulfilled. The scientifically organized hospitals, the large medical clinics and their multiple laboratories, the institutes for medical research in this country and in Europe, by merely continuing the investigations in which they are at present engaged, will, without any doubt, immensely advance our knowledge of the nature and mechanism of disease. But fundamental principles have to be discovered; entirely new fields must be opened,

and this can be accomplished only by the development of pure science.

Science, when connected with medical research, does not go far enough from the beaten road, and is often handicapped by its attempts to make useful discoveries. On the contrary, pure science has no immediate practical purpose. Its object is merely to find the truth and to understand the universe. It does not attempt to make discoveries that could be applied to industry or medicine, but seeks an accurate conception of the world in which we live, and of our relations to it. Pure science classifies the empirical knowledge of nature that we already possess. Beyond the apparent and often puzzling complexity of phenomena, it detects the common element that underlies their seeming diversity. Then it can draw the generalizations which we call laws, and predict and reproduce the phenomena at will. The understanding of nature always has led to its control. Pure science which seeks knowledge in an absolutely disinterested way becomes, almost in spite of itself, the great power of this world. There is no other manner of obtaining a thorough knowledge of nature and of applying the forces with which it can be mastered.

Physiology As a Pure Science

If physiology were studied as a pure science far from hospitals and medical schools, by men possessing the creative imagination and the spirit of the discoverers of the fundamental principles of physics and chemistry, the secrets of the functions of the body that we still lack would be brought to light. These discoveries would indirectly lead the physician to understand the nature of the diseases of the organs whose functions are incompletely known today, and to prevent them. This institute of pure science where physiologists, physicists, and chemists could devote themselves to the investigation of fundamental problems would also create the proper conditions for the building up of the science that will occupy the summit of the hierarchy of human knowledge, the science of thinking matter and energy.

Immense Task of Development

The development of this new psychology is our only hope of improving the quality of human beings. But it will be an immense task, because the structure of the central nervous system, as unveiled by Ramon y Cajal, is of infinite complexity. It is probable that the discoveries which will open this field to scientific investigation will be made on the frontier of physiology and physics, and will require the development of entirely new methods by some man of genius. Modern psy-

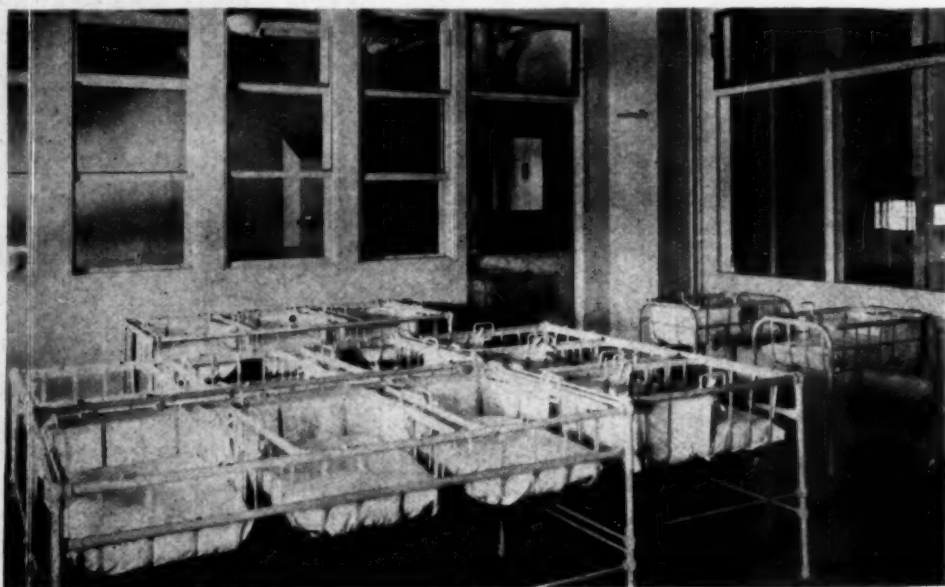
chology, in spite of its progress, will have the same relation to this supreme science as alchemy to the chemistry of our day. Our knowledge of cerebral physiology is in the embryonic stage. We are still entirely ignorant of the properties of nerve cells, the nature of nervous energy, and the significance of telepathic phenomena. No one suspects the manner in which memory, intelligence, courage, judgment, and imagination are connected with the brain cells.

Another Untouched Field

The possible affinity of certain structures of the brain for some chemical substances secreted by endocrine glands and other tissues has never been studied. While courage may be caused by the effect of the sex glands on the cerebral cells, and may not be due to a property inherent in those cells, creative imagination, judgment, and other qualities possibly require for their development the action on the nervous system of substances produced in other parts of the body, or possibly introduced into the organism with the food. The knowledge of the conditions that permit the evolution of judgment, imagination, kindness, or courage in a race, family, or individual, or of the conditions that bring about the disappearance of these qualities, would give the human race far more happiness than the complete eradication of plague, cholera and typhus from the earth. At the same time, the discovery of some of the fundamental properties of nerve tissue would enable medicine to prevent many of the nervous and mental diseases that today exact such a large toll of victims.

Knowledge of Brain Functions

It is obvious that the functions of the brain must be better understood in order that, without intellectual or moral deterioration, the human race may stand the new conditions of life imposed on the individual by modern civilization. The spiritual progress of man could be greatly promoted by a scientific knowledge of the physico-chemical phenomena that take place within the brain cells. Instead of merely increasing the number of human beings, we could increase their quality. The progress of medicine, understood in this manner, would be the most important factor in the development of civilization. As Descartes wrote three hundred years ago, we must ask from medicine the solution of the problems that are vital to the greatness and happiness of the human race—"c'est à la médecine qu'il faut demander la solution des problèmes qui intéressent le plus la grandeur et le bonheur de l'humanité."



*Glimpses
of
Nurseries
in
Various
Hospitals*

Above is the nursery at the Boston Lying-in Hospital, Boston. On the right is the nursery at St. Mary's Hospital, Wausau, Wis., an institution of sixty beds.



On the left is a typical nursery at the recently completed Maternity Hospital of Cleveland, an institution of 120 beds.

WHY HOSPITAL PROPERTY IS DESIRABLE SECURITY FOR MORTGAGE LOANS

By Festus J. Wade, President, the Mercantile Trust Company,
St. Louis, Mo.

DOUBTLESS in the minds of many investors, and the public generally, there is a sincere desire to know more about the real stability of hospital property as security for mortgage loans.

To the average citizen, a hospital is merely a place where one goes when he is sick, or when he requires an operation. He has little or no knowledge of the financial aspect, excepting perhaps at one time or another he may have had occasion to transact business at the cashier's window, or possibly was a contributor to an endowment or building fund. But the seeker after information and facts goes into the question more deeply. He sees in the modern hospital a large investment, both in land and buildings, as well as equipment, and begins to wonder why securities, based on such institutions, should not be placed in the same category, from an investment standpoint, as mortgages on office buildings, commercial structures and other properties which seem to enjoy more popular favor.

It is true that hospitals are classed as single purpose or specialty buildings. This classification at once arouses fear in the mind of the uninformed investor, but he loses sight of the fact that these institutions, especially those under the jurisdiction of one of the large religious denominations, have behind them a tremendous asset in the way of moral background. Then, too, every community has a certain pride in its local hospital. These two factors, the moral risk and the good will of the community, are strong features, and they tend to minimize the danger of the foreclosure. They are elements usually absent in strictly commercial ventures, but are so pro-

nounced in hospital loans as to offset the apparent lack of diversity of use.

At this point, in order to obtain a clearer and more definite understanding of the desirability and soundness of hospitals as security for mortgage loans, it might be well to give a short survey of the development of institutions of this character.

The present modern hospital system dates back to ancient times when there existed institutions

of various sorts for the care of the sick. Later, with the spread of civilization and the foundation of monastic orders incident to the beginning of the Christian era, great strides were made for the systematic care of the sick and ailing.

In Europe there are now in existence hospitals which were founded as far back as the Sixth Century, and in America the first institution of this kind was established many years before the Revolutionary War. Naturally, hospitals in this country were modeled on European methods, but in later years, in America, such rapid

strides and substantial progress have been made in structural features and architectural design that we are now far in advance of the Old World in many things relating to efficiency and modern methods.

It is apparent that from their beginning hospitals have been considered one of the essentials for human existence, and every student of finance will concede that whatever is an absolute necessity for the requirements of civilization, whether it is a roof over one's head, or a place in which to transact business; a railroad, or other public utility, is excellent material upon which to base investments.

More Opportunity—Less Risk

"REMEMBERING that there is no danger of default by reason of non-payment of general taxes on hospitals proper; that the question of renewing franchises is never brought up, and that hospitals are not subject to strikes or adjustment of rates by municipal authority, nor do they have to contend with other ills to which business corporations are heir, it is obvious that a mortgage on an institution of this character, properly safeguarded, is a safe investment.

"In fact, if the records were scanned and foreclosures on hospitals were taken as a basis for comparison between real and other investments, the comparison would reduce the average of foreclosures to such an extent that the real estate mortgage would, as far as stability is concerned, outrank corporation securities."

Furthermore, remembering that there is no danger of default by reason of non-payment of general taxes on hospitals proper; that the question of renewing franchises is never brought up, and that hospitals are not subject to strikes or adjustment of rates by municipal authority, nor do they have to contend with other ills to which business corporations are heir, it is obvious that a mortgage on an institution of this character, properly safeguarded, is a safe and sound investment. In fact, if the records were scanned and foreclosures on hospitals were taken as a basis for comparison between real estate mortgages and other investments, the comparison would reduce the average of foreclosures to such an extent that the real estate mortgage would, as far as stability is concerned, outrank by a wide margin corporation securities.

Demand for Modern Hospitals

The enormous increase of our population and the advanced standard of living have resulted in a demand for modern hospitals to replace those built many years ago, which fail to conform to present-day needs. There has also been an insistent demand for new buildings to take care of communities that were inadequately served or were without hospital facilities. That those in charge of hospitals are alive to the situation is evidenced by recent statistics showing that in the past few years hospital construction throughout the United States has kept pace with general building conditions in quality as well as quantity. Millions of dollars have been spent, and millions more will soon be expended on new buildings.

Finances Often Cause Delay

The financing of these structures years ago would have been a problem, but the way is now more clear and simple, owing to better and more modern business methods. Formerly, the erection of a new building, or an addition, was dependent on the generosity of some person, or group of persons, to pay the cost of the contemplated structure. If the funds were not forthcoming in that manner, construction was deferred, notwithstanding the fact that the new building or addition was necessary to take care of present needs. Thus both the community and the institution suffered.

However, modern hospitals adopted modern methods and followed the practice of the business man by financing improvements through mortgage loans. This method provided the funds at once for the construction work, repayment being made through a period of years. That this plan has proved mutually advantageous is evidenced by

the fact that the Mercantile Trust Company of St. Louis has in recent years financed, to the extent of many millions of dollars, scores of hospital buildings in various sections of the United States, and in every case the loans have worked out to the satisfaction of all concerned. These loans were made on the serial plan of payment, that is, the plan by which the principal debt is divided into \$500 notes, a specified number of which are payable annually. These notes, with interest coupons attached, payable semi-annually, are sold to investors, and it is a splendid tribute to the faith of the investing public in hospitals generally, that the popularity of this form of investment is becoming greater every day. These serial payments make it easier for the mortgagor to pay the debt and, at the same time, enable the investor to choose any maturity he desires.

Despite our successful record, it cannot be taken for granted that an investment is safe and sound because of the fact that it is part of a hospital loan. The same precautions should be taken in financing that class of property as in making loans on ordinary real estate. The mortgage should contain the usual provisions assuring prompt payment of principal and interest. Proper insurance should be carried for the protection of the note-holders, and the same businesslike methods should be employed in loans on business or commercial properties.

With a proper background of physical property, a location adapted to the needs of the community and an efficient management, there is no reason why a hospital should not obtain the same consideration in its financial matters as the merchant who finds it necessary to borrow money to erect a new building or extend present quarters.

LET THE PUBLIC KNOW THE COST

One of the oldest ideas prevalent in communities, and still prevalent to a very large extent, is that the hospital is a philanthropic institution and that the person going there for care should not be required to pay, or if he must pay, that the charge should be very low, according to S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich.

We see vast numbers of people making no provision in their budgets to meet the sudden onset of illness, of an operation, or of hospital care, and when this condition arises they rush to the hospital without a cent in reserve to pay for that care and expect that institution to care for them without any charge.

Parallel with this we have the man earning a fairly good salary, who is willing to pay the hospital charges but who complains bitterly if those charges are in excess of what he thinks such charges should be. The hospitals are largely to blame for this condition. The public has not been informed of the situation or of the cost of operation. We are almost a secret organization in the minds of the public.

WHERE CHRONIC PATIENTS ARE RECEIVING SPECIAL CONSIDERATION

By A. C. Jensen, Superintendent, Alameda County Hospital,
San Leandro, Calif.

IT IS a common practice in county hospitals, especially in the smaller institutions, to keep chronic patients in the acute wards or to place them in a ward that is not equipped as a hospital and where they cannot be given hospital care.

Both practices are bad. That of keeping them in the acute ward has a tendency to lower hospital standards, as the chronic patient does not require the same care as the acute patient. When placed with acute patients, chronics often become problems of discipline and increase the cost of operation; however, the main objection to this practice is the unfairness to the chronic patient. Chronic patients should be segregated in wards where consideration can be given to their special needs for entertainment, employment through occupational therapy, and development of interests that will keep them contented.

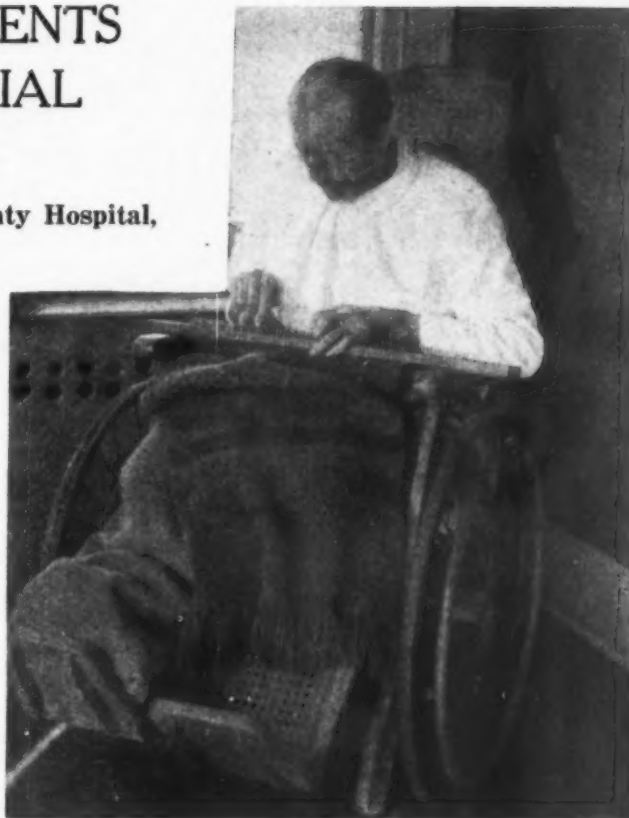
In planning a building, provision should be made for segregation of various groups without making care and supervision difficult. This is done by use of partitions with the upper half of glass, and by part partitions of similar construction dividing the larger wards and some single rooms. In this manner it is possible to segregate into groups the senile, those of the same nationality, especially when unable to speak English, the noisy and troublesome patients, and groups who are congenial; the single rooms being assigned those suffering from diseases causing unpleasant odors, and for very sick or dying patients.

At the Alameda County Hospital the wards are light and airy. The interior is finished in warm cream and buff color. There are wide halls and doorways, and steps have been eliminated to permit cripples and patients in wheel chairs to get around.

Each Ward Has Solarium

Each ward has a pleasant solarium where patients may escape the monotony of ward surroundings and have a place to smoke, visit, read, or work. There is a convenient exit to an outside court provided with comfortable seats, and with plants, flowers, fish pool, and aviary.

Sufficient locker space is provided patients where they can keep personal belongings such as



Chronic patient making a shawl.

are not needed by acute patients. Lavatories are located near the solarium and the outside court; and utility rooms, hopper room, and nurse's station are centrally located.

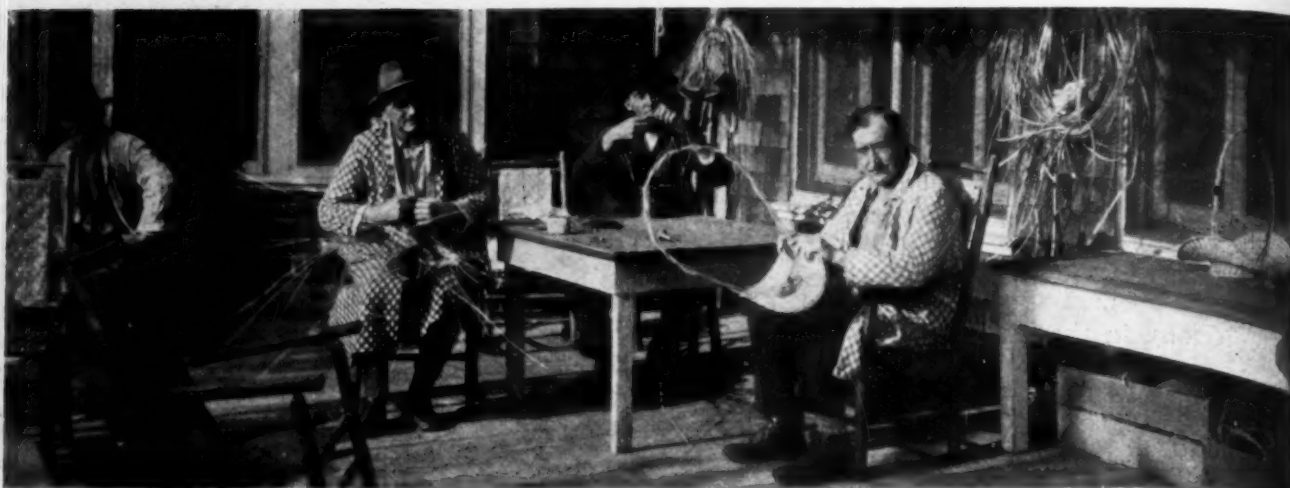
Wards are equipped with standard hospital furniture and a generous number of wheel chairs. To care for the large number of involuntary patients there is a room equipped with a sufficient number of bedpans and urinals and facilities for the care of these utensils including a clinic sink, rack for draining and drying which is located over the radiator, container for soiled linen, rack for cleaning rubber sheeting, and refuse containers.

Treatment Room Equipment

The treatment room is equipped with examining table and necessary instruments to give the needed medical care. There is also a dressing carriage fully equipped. A regular nurse's call system is installed.

The medical staff is so organized that there is a department of chronic medicine and surgery with interns and visiting staff. Although the patient is suffering from a chronic disease much may be done to alleviate his suffering and many patients are, at least, partially rehabilitated.

The most important factor in the care of chronic patients is in securing a nurse who is specially



Ambulatory patients working on the hospital porch

interested in this type of work. Among the many qualifications of a good administrator are, ability to be absolutely impartial, congenial, sympathetic, and possessed of a genuine desire for service. The supervisors are graduate nurses with special qualifications and are compensated accordingly. The male wards are supervised by a male nurse assisted by orderlies, and the female wards by female nurses assisted by ward maids. There is one nurse for each twelve patients. The chronic patients in the county hospital are mostly old people and their greatest need is physical care.

Treatment Value Recognized

The value of occupational therapy has been recognized in the treatment of younger patients suffering from chronic diseases, especially in government hospitals, but its value has been overlooked in the care of the older chronic patients

such as are usually found in county hospitals. One of the greatest needs of this type of patient is something to occupy the mind and furnish an interest in life. Many forms of occupational therapy are admirably adapted to their needs such as, making baskets and weaving by the ambulatory patients; reed work, shawl making on frames, matting, knitting, crocheting, etc., by the wheel chair and bed patients. Emphasis is placed upon producing articles that have a commercial value. The patient receives one-half of the sale price which gives him an incentive and develops his interest. An effort is being made to give every patient who is able to work some interest to occupy his mind.

The hospital librarian visits the wards regularly, supplying patients with books and current magazines and through personal contact with the patients stimulates interest in reading.



The pleasant courtyard where every effort is made to provide comfort in either shade or sunshine

The wards are wired for radio and have connections for bed-fast patients permitting them to connect ear phones, and the solariums are provided with loud speakers.

Religious services, picture shows, and other forms of entertainment are available for ambulatory patients, and occasional entertainments are brought to the wards.

By segregating chronic patients, and with careful planning of the wards and organization, it has been possible to give the chronic patient those things which he needs at a cost much less than that in acute wards.

THE INTERN PROBLEM, TWO SUGGESTIONS

By Hugh Heaton, M. D., Willard Parker Hospital
New York

Interns are sometimes cataloged in the hospital executive's mind as one of the necessary evils that go with the job. They are members of the personnel but often fail to become a part of the organization. No one as far as can be learned has solved the intern problem, either from the executive's standpoint or that of the intern.

The intern and the superintendent are far apart in their attitudes toward the work to be done. The intern looks on his residence in the hospital and his service in the wards as an extension or prolongation of his academic training. The four years in medical college and the year's internship are cut from the same cloth. He paid his dollars for tuition in college and now he is paying with his valuable time and services for the completion of his training. To him the hospital is where he gets something that he needs. He does not approach the internship as an employee who is bound to render a service for his board and keep; quite the contrary; the hospital, he thinks, is bound to round out his training as well and as quickly as possible so that he may be out earning the large fees that his mind has been picturing for years.

Initiation to Routine Needed

Moreover he is still a youth, and youth accepts without thought or sense of gratitude all that the world gives. Of the rules and customs of the hospital he knows nothing and cares less, so long as they do not interfere too much with what he regards as his rights and privileges, in which case they are things to be broken or avoided. He knows nothing of the organization of the hospital, its complexity and contacts. To him the hospital is the place where he can find gathered together for his convenience the greatest number of "cases" for him to study and practice upon. He knows nothing of heat, light and power, feeding, and serving, buying, storing and issuing, inspiring and directing, sustaining and condoling. He knows nothing of the hospital's relation to patients as human beings. These things the superintendent has with him always and in addition he has interns.

It is not the intern's fault that he knows nothing of these things. He has never in his medical or pre-medical education been told of any of them. He has had no instruction about hospital organization. He does not know how hospitals are financed. He has never had fixed in his mind the hospital's place in community service, its opportunities and limitations. To him hospitals just are, have been and will be. To him the superintendent, if a doctor,

is a sort of a freak who has side-stepped from the great highway of medicine and must therefore be of doubtful credit to the profession. If the superintendent is a layman the intern feels that he is, therefore, not of the "elect."

I have two suggestions. First, somewhere in the curriculum of the medical college the student should be told about hospitals as organizations, their place in medicine, their complexity and the necessity of the correlation of all the parts into a unified, living, feeling thing. He should be told that patients in a hospital are human beings and not "cases," and that the superintendent is a man who has chosen hospital administration as his specialty in medicine.

My second suggestion is that an intern's first week in the hospital should be spent entirely with the administrative phase of hospital activity. He should accompany the superintendent or his assistant on their rounds, be present at conferences, spend a day with the housekeeper, the engineer, and the dietitian, go from roof to sewer and back again, learn the hugeness of the plant. He should learn that the patients own the hospital and that no one in or out of the hospital, high or low degree has any right or privilege that conflicts with the needs of any patient. Tactfully it should be brought home to him how great is his privilege in coming into this organization, and that this privilege is not given him for his benefit but for the benefit of mankind whose servant he is to be. If he is not of the impossible kind he will grow more in that week, become more mature, align himself more closely with great purposes, than in any other week of his career. If he should be of the impossible kind the superintendent will learn of it and can act before damage is done.

COLLECTING PAST-DUE ACCOUNTS

If the small hospital in the small town is to maintain its good reputation, it is essential that the patients must be made to pay their hospital bills. As the superintendent of a thirty-bed hospital in a town of 10,000 population puts it, "the people of a small town or at least of this community will think more highly of the institution and have greater respect for the superintendent if they are made to pay their hospital bills when they are due."

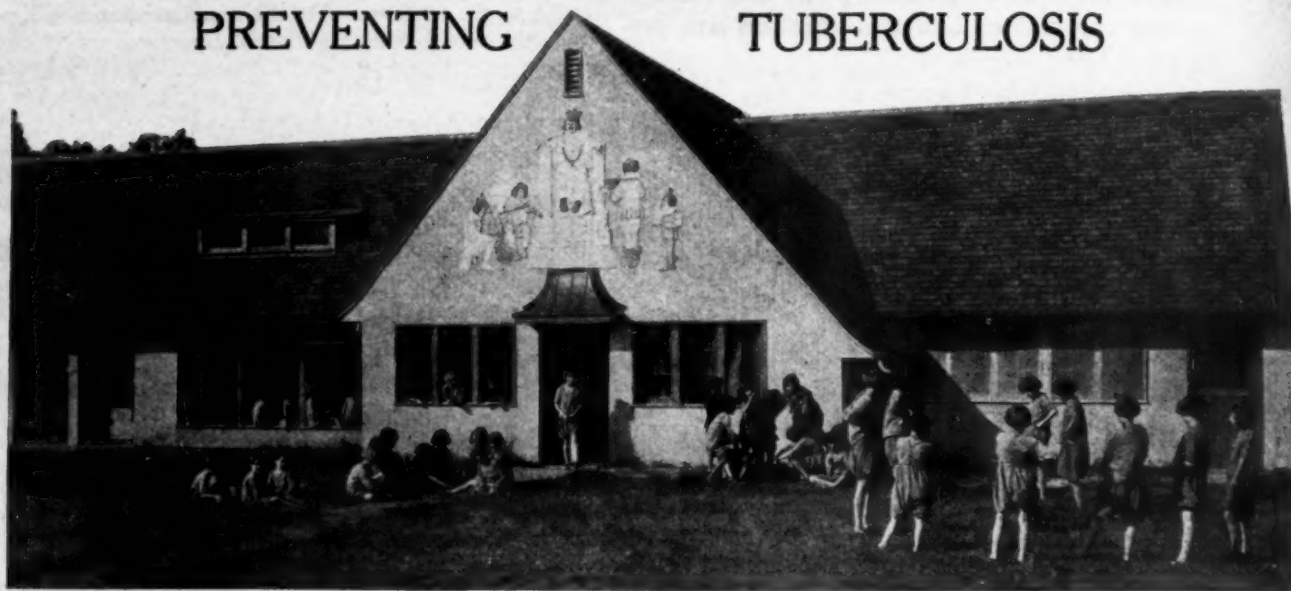
"When a bill is outstanding the debtor is continually subject to the unwelcome statements, or the visits of a collector. And since the community is small, the antagonism naturally concomitant with such procedure is more apparent and influential than in the large, metropolitan centers.

"Few families in the smaller towns are as impoverished as are those in large industrial centers. And since the community is so small as to make every family known to every other and because credit rating in no way affects the social standing of a small town citizen, we are forced to employ what may seem to some superintendents rather harsh methods of collection.

"No patient with an unpaid bill ever leaves this hospital without seeing me personally and making some sort of written definite schedule for payment.

"In my opinion, one of the major reasons why so many small hospitals fail in the matter of collections is because they do not appreciate the value of continuity of effort. As a rule the small hospital in the semi-rural community doesn't have any great number of names in its accounts receivable column. Furthermore, the superintendent is, or should be, personally acquainted with all the patients. He or she should know where the patient works, his income, and whether that income is received weekly, semi-monthly or monthly, and collect accordingly."

DETROIT'S INTERESTING METHOD FOR PREVENTING TUBERCULOSIS



By Bruce H. Douglas, M.D., Superintendent, Spring Hills Sanatorium, Northville, Mich.

THE summer camp idea has become popular in the past few years and rightly so. In many places it is being combined with the idea of health from the recreational and educational standpoints. Camp Forest Hills, which is conducted by the Department of Health of the City of Detroit, in conjunction with the Spring Hills Sanatorium for Tuberculosis, is a summer camp for children with the health objective uppermost, in an attempt to prevent the development of active tuberculosis among children who have been exposed to the disease.

In the summer of 1920 the Detroit health department conducted the first camp on the then recently purchased site for the Spring Hills Sanatorium. The equipment consisted of army tents and cots, and while the camp was a decided success, it was thought that accommodations of a more permanent character would be more satisfactory

for the future. Consequently, the pleasing group of buildings with their Mother Goose pictures, peaked roofs and vari-colored shingles was planned and constructed, and the Ginger Bread Village has come to be known quite widely as one of the most unique of camp groups.

Since 1921 each summer many children come from homes where tuberculosis is already known to have attacked at least one member of the family, and after spending several weeks in the fresh air and sun light, go back with a better physique and a more complete knowledge of how to keep well.

The camp buildings center around a two-story building, the first floor of which contains the large camp dining room and kitchen. The second floor houses the nurses and recreation directors for the camp. On both sides are dormitories housing fifty children each, and extending to the east is a fourth building for rec-



Main entrance to one of the dormitories.

reational purposes, which also contains a large room that can be used as an infirmary, when necessary, and two small rooms for the housing of the chef and the other help. Adjoining this building is the tower which serves as a storeroom. Toilets and shower baths are in separate buildings, one for boys and one for girls, placed close to the dormitories. There are limited toilet facilities in each dormitory for night use.

The staff necessary to conduct the camp, which cares for one hundred children at a time, consists of a chief nurse, four general duty nurses, four recreation teachers, chef and helper, a janitor and five women waitresses. The doctor comes from

the regular staff of the sanatorium, where he is in charge of the children's department. Supplies are obtained through the sanatorium commissary, and the laundry is cared for by the sanatorium laundry. Since the camp is operated in conjunction with the sanatorium the expense has been lessened in many respects.

The children range in age from six to twelve years, and there are about as many boys as girls. Starting June 1, it is possible to conduct two eight-week sessions, and close by October 1. The buildings are open only during the four warm months as they are not constructed or equipped for use in cold weather.

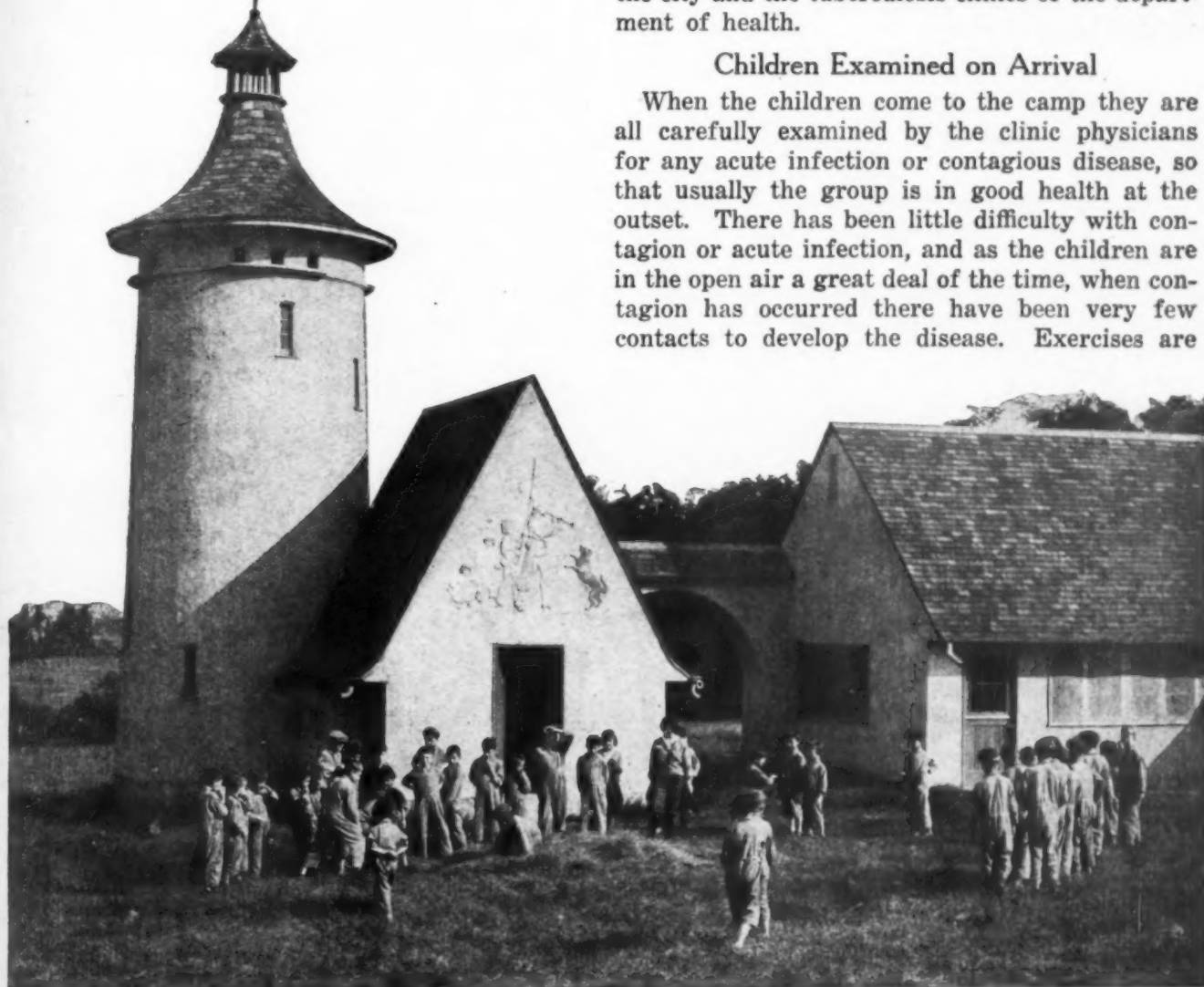
The selections are made primarily from families where tuberculosis has already been detected in some other member of the family. Vacant places are filled by undernourished children who may easily become attacked by the disease but who have had no direct contact with tuberculosis. These children are selected through the nursing and medical personnel of the open-air schools of the city and the tuberculosis clinics of the department of health.

Children Examined on Arrival

When the children come to the camp they are all carefully examined by the clinic physicians for any acute infection or contagious disease, so that usually the group is in good health at the outset. There has been little difficulty with contagion or acute infection, and as the children are in the open air a great deal of the time, when contagion has occurred there have been very few contacts to develop the disease. Exercises are



Early morning play-time for a group of young boys in front of the tower storeroom.



regulated for the individual on the basis of the examinations.

The children are given clothes of uniform khaki material, so that it is easy to keep track of the clothing. Each child's clothes are then put away until he goes home. Each child is re-examined upon discharge and recommendations are made for future care.

While in camp all have their teeth examined and the needed treatment given.

These children are followed up by the visiting nurses and, in many instances where there is need, they are returned to the open-air schools.

The child's day at camp is planned according to the following schedule.

Breakfast, 7:30 a. m.
Care of quarters, 8—8:30 a. m.
Play (directed), 8:30—10 a. m.
Mid-morning nourishment and rest, 10—10:30 a. m.
Play (directed), 10:30—12 m.
Dinner, 12 m.
Rest hour, 1—3:00 p. m.
Afternoon nourishment, 3 p. m.
Play, 3:15—5:15 p. m.
Supper, 5:15 p. m.
Play, 5:45—7 p. m.
Bed time, 7 p. m.
Lights out, 8:00 p. m.

The nurses supervise the rest periods and the night care of the children, and the recreation teachers direct the play periods. The children are not allowed to play strenuous running games at any time, and any child who does not make the proper improvement or loses weight, is taken off exercise until improvement is shown.

While the daily program seems a little hard at first to some of the children who are not used to an afternoon nap and such an early bed time, usually at the end of the first week they are all adjusted to it.

Sessions of Eight Weeks Best

After trying different lengths of stay, the eight-week camp session seems to be the most advantageous. Underweight children will usually make their best gains in this time. A shorter time is not sufficient to bring them to normal, and a longer period generally means that the gain levels out and stops soon after the eighth week. The eight-week period is long enough to make a clean break from home environment and permits the child to build up his resistance to face his surroundings when he returns home.

To measure results in efforts of this kind is somewhat difficult, but there are some quite striking things that stand out, indicating that it is decidedly worth while. For instance, in the last four years seven hundred and seventeen children have attended the camp. Of this number only

nine have had to be admitted to the sanatorium as tuberculous. Of course, some of the number have been lost track of after going home, but this undoubtedly represents the majority of them, and speaks well for the preventive work of the camp.

Another evidence of the value of this enterprise is the improved nutrition that results from the child's attendance at camp. The following table will indicate the actual gains for the past four years:

Year	No. of Children	Average Stay	Average Gain
1922	100	7.5 weeks	4.2 lbs.
1923	208	7.5	5.8
1924	204	7.4	5.7
1925	205	7.7	4.8
4 yr. record	717	7.5	5.2

In these years only two children have lost weight while at camp and this occurred because of acute conditions that had developed.

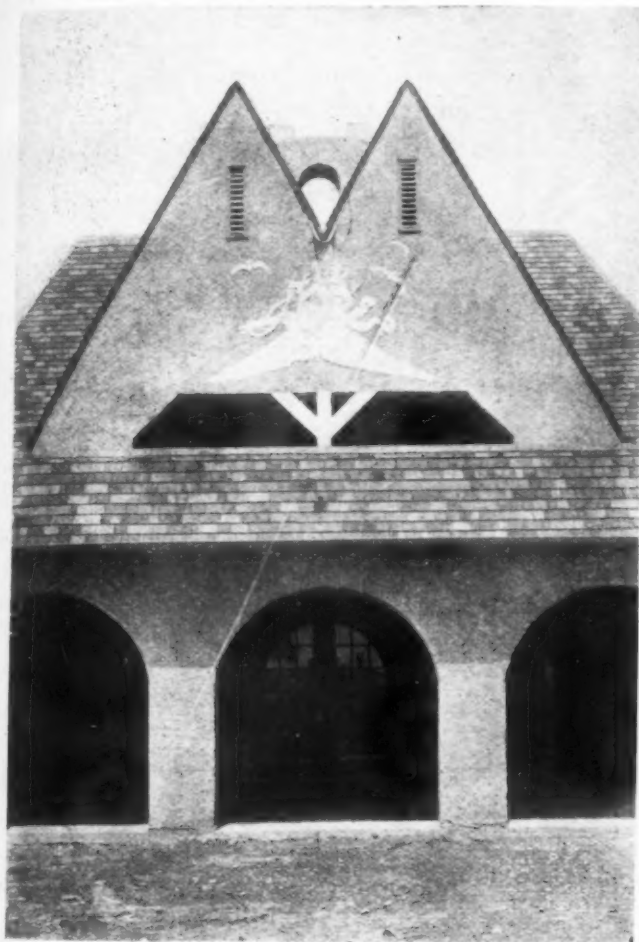
Still another interesting result that shows the work done at camp is not lost when the child returns home was brought out by checking up one hundred children in camp the summer of 1922. A year later it was possible to find sixty-eight of them with the following findings.

This group entered camp 13 per cent under weight on the average, according to the Wood scale, and left camp $7\frac{1}{2}$ per cent under weight. One year later this was further lowered to $3\frac{1}{2}$



Entrance at end of one of the dormitories, showing the adaptation of nursery rhymes.

per cent under weight, which is well within the normal, and indicates that the stay at camp had given an impetus in the right direction for these children and the gain had continued.



Decorated porch entrance to camp dining room and kitchen.

The above findings, together with the improved appearance and better physique, found on examining these children after staying at camp, indicate that a real piece of preventive work is being done. It is carried to the rest of the family too that the foundation of health habits is of great importance in keeping well. The parents and other members of the family see what fresh air, regular hours and good food will do for the child, and, moreover, the child himself becomes a missionary for healthful living among his associates and schoolmates.

The appropriation for this camp amounts to \$15,000 a year for maintenance, and there is never any difficulty in convincing the people of Detroit and the appropriating bodies, that this is a worth while project upon which to expend public funds.

Camp Forest Hills is an outstanding example of the value of the camp type of preventive work among children.

WHERE EXPANSION IS BETTER THAN REPLACEMENT

A few years ago state hospital authorities contended that twelve or fifteen hundred mental patients was the maximum that could be cared for properly in one institution. With modern improvements in administration and organization, and with more experienced personnel, a state hospital of five thousand patients may be handled as efficiently as a smaller one. This being so, the economical course is to develop the old institutions by purchase of more land, additions to service departments, such as kitchens, bakery, power plant and laundry, and to the staffs. The aggregate cost of such additions would, in no instance, approach the sum necessary to build and equip a new institution. An investment of from two to two and one-half million dollars is necessary before a single patient may be received in a new state hospital. As states build, it requires usually from four to five years to prepare a new institution for its first patients. Expanding the capacity of an existing institution requires little time, and practically all of the money available may be spent for bed space.

There are many arguments in favor of the five thousand capacity state hospital. There are many such hospitals in the United States and they are doing good work. Men are being trained and methods are being devised for the administration of such units. Indeed, when a hospital has reached the magnitude of five thousand patients, the probability is that even politicians will hesitate to tamper with it. Better executives and better organization will have a tendency to crowd out politics, and will afford the sick better living conditions and a better chance of recovery than they have in smaller institutions.

It seems clear that present conditions, complained of generally throughout the country, might be improved if the states would deny themselves some other things for a year or two and use the funds thus saved to enlarge state hospitals after the simple manner indicated.

THE COST OF MATERNITY SERVICE AT HOME AND IN THE HOSPITAL

If maternity care is given by a general practitioner either in a patient's home or in a hospital, the minimum cost will be around \$150; better care can be procured for \$100 more. The service of a specialist raises this minimum to between \$400 and \$500. Treatment by mid-wives and the outdoor hospital service cost correspondingly less. In round figures, we may say that for the rank and file of the community, provided no abnormalities of labor occur, it costs from \$200 to \$300 to be born.—*Bulletin Metropolitan Life Insurance Company.*

THE PLACE OF CHRONIC AND CONVALESCENT HOSPITALS IN THE CARE OF THE SICK

By Ernst P. Boas, M.D., Medical Director, Montefiore Hospital for Chronic Diseases, New York

WITH the present tendency toward the development of specialized types of institutions for different classes of patients, it becomes important to define clearly the fields that should be covered by the respective institutions. At present it is the functions of the chronic and convalescent hospitals that seem chiefly to be in need of further delineation.

General hospitals are planned to serve the needs of patients suffering from acute or complex illnesses that require a few weeks' expert, highly specialized institutional care. The per capita cost of general hospitals is thus higher than that of other institutions and the demand on their beds is constant. Moreover, chronic and convalescent patients are frequently neglected in general hospitals because attention is so generally centered on active and urgent cases.

For the sake of economy and efficiency, as well as for the best interests of the patients, other types of institutions must assume the burden of care when illness becomes unduly prolonged. Both the convalescent home and the hospital for chronic diseases supplement and complete the work of the general hospital by undertaking the problem of prolonged rehabilitation extending over many weeks or even months. Convalescent homes and hospitals must further be subdivided into general and special convalescent homes. Among the latter, the most important are those dedicated to the care of sufferers from heart disease, chronic infections of the bones and joints and mild psychiatric disorders not warranting commitment.

The chief criterion, by means of which the distinctive character of these several types of supplementary institutions can be established, is the amount of medical care required by patients. The concept "medical care" embraces the specialized professional equipment used for diagnosis and treatment as well as the specialized medical per-

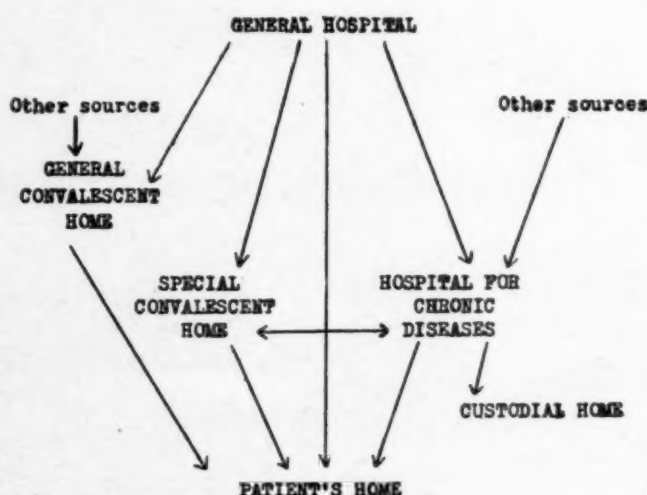
sonnel consisting of physicians, nurses, dietitians and technical aids that must be supplied by the institution. The general convalescent homes giving a few weeks' care to patients who have just passed through a major medical or surgical illness, or to individuals who are weak and undernourished, or, as the saying is, "run down," are confronted by no highly technical medical problems. They must be equipped for simple surgical dressings, and re-

quire on their resident staff a few skilled, trained nurses and a dietitian. A resident physician is usually unnecessary unless the institution is very large. The organization of the special convalescent homes or hospitals will depend on the character of their patient material. For instance, one devoted to the care of children suffering from bone and joint tuberculosis must be equipped with a plaster room, a brace shop, certain or-

thopedic apparatus, and an x-ray machine. The nursing personnel must be more skilled and medical supervision is more imperative.

Similar distinctive considerations apply to the cardiac convalescent home that would fulfill its proper function of caring for sufferers from rheumatic heart disease in the immediate postfebrile stage. Hospitals for chronic diseases, on the other hand, should duplicate in every respect the equipment and professional personnel of general hospitals. They are called on to diagnose and treat the most complex diseases and must be provided with every diagnostic and therapeutic aid known to medical science. In the custodial division of hospitals for chronic diseases no medical care need be given.

The likelihood of achieving rehabilitation of their patients serves further to distinguish these various institutions. It is the function of the convalescent home to restore the patient to functional and economic usefulness, while the hospital for chronic diseases must treat not only individ-



The interrelation of chronic and convalescent hospitals in the care of the sick.

uals capable of restoration to complete or partial health, but must also care for sufferers from long drawn-out disabling diseases, who require long continued institutional care; as well as provide a custodial home for those derelicts of disease for whom there is no longer any hope of cure or improvement.

The community hospital requirements, therefore, leaving out of consideration for the moment the psychiatric and tuberculosis problems, may be outlined, as follows:

1. General hospital
2. Special hospital
3. General convalescent home
4. Special convalescent home
 - a. Cardiac convalescent home
 - b. Orthopedic convalescent home
 - c. Psychiatric convalescent home
5. Hospital for chronic diseases
 - a. Hospital section
 - b. Custodial section

These several types of institutions must take coordinate rank in the treatment of disease and must be given autonomy for independent growth and development, for each has its unique, highly specialized problems. It would seem inadvisable for a hospital to develop and operate its own convalescent home, for with such an arrangement, the interests of the convalescent home would always be submerged in the interests of the hospital. But there should, of course, be close cooperation and a clear definition of responsibilities of the several types of institutions.

Serve Needs of the Poor

Whereas, the general hospital is needed by rich and poor alike when overtaken by the urgency of a serious illness, the convalescent home and chronic hospital serve more particularly, but by no means exclusively, the needs of the poor. Families that are moderately well-to-do can often obtain adequate medical care of a less specialized and exacting nature without institutional assistance.

A patient may be discharged to his home from a general hospital, provided he has recovered from his illness and his home environment is such that he can be taken care of until he has completely regained his strength. Under adverse economic circumstances, however, such a convalescent from an acute infectious disease or from a major surgical operation should be transferred to a general convalescent home for a period of several weeks to complete his recovery. From the general convalescent home he is then returned to his family. The general convalescent home may receive, in addition, patients referred by dispensaries or by private physicians, who are in need of its special services.

To illustrate the role of the special convales-

cent home, we might follow the course of patients suffering from valvular heart disease following acute rheumatic fever. During the acute febrile stage such patients become charges of the general hospital. Ordinarily, within a week or two after the subsidence of their fever, as soon as they are able to get out of bed, they are discharged from the hospital either to their homes or to a cardiac convalescent home. It is well known that recurrences of rheumatic fever are very common and that not infrequently they are determined by a lighting up of an infective focus remaining latent in the body.

Use of Convalescent Hospital

Moreover, it may take months for the actual inflammatory process in the heart to subside. Such patients should be kept under close observation for months after their acute infection; their period of bed rest should be greatly prolonged and their return to complete physical activity should be greatly delayed. During this period they need not be retained in a general hospital but should be transferred to a cardiac convalescent hospital.

The present cardiac convalescent homes are not equipped to care for this type of patient. They admit ambulant undernourished individuals who happen to have organic heart disease. Such individuals require only general convalescent care and should be placed in general convalescent homes.

The true cardiac convalescent home or hospital must be prepared to give prolonged bed rest and occasional specialized medical care to its inmates. The general handling of patients should be analagous to that of patients in a tuberculosis sanatorium. The patients should be kept until they are well enough to be sent home. Unforeseen complications may necessitate transfer to a chronic hospital. On the other hand a patient whose condition has undergone considerable improvement after a course of treatment in a chronic hospital may be benefited by a final period of residence in a cardiac convalescent home.

Dividing Line Not Absolute

The dividing line between the special convalescent home and the chronic hospital is difficult to draw and is by no means absolute. In smaller communities a well planned chronic hospital can provide adequately for patients requiring special convalescent care, except for the psychiatric group. In larger centers with a greater number of patients the more specialized institutions may be more desirable.

The chronic hospital accepts patients from general hospitals or from other sources, whose ill-

nesses are prolonged, disabling and complex. The chief distinguishing feature between it and the general hospital is its policy of retaining patients for as long a time as they may need hospital care. In equipment and staff it must duplicate the general hospital. Fully 45 per cent of its patients will need expert hospital care. Another 30 per cent will need skilled nursing and the remainder will demand only custodial care. About 30 per cent of the patients treated during a year will be sufficiently improved to be discharged to their homes, and about 18 per cent will die. From one-quarter to one-third of the patients admitted will, after having been properly studied and treated, require only elemental custodial care. At this stage it is poverty not illness that compels them to seek relief in an institution for chronic diseases.

Only Requirements Are Simple

For such individuals the provision of bed and board, of a little assistance in dressing, bathing and eating, is all that is necessary. Yet at best their physical condition is precarious. Frequently new complications set in, or the old disease again progresses, necessitating renewed hospital care.

In order to avoid unnecessary costs chronic patients who no longer require medical treatment should be discharged from the wards of the chronic hospital. They should be returned to their families if the latter are able to assume their care. If, as is too often the case, the relatives, because of their poverty, are unable to receive them, they must be accommodated in a separate wing or building of the chronic hospital, which is especially planned for them. Such custodial wards should be in organic connection with the hospital service, so that patients may be freely transferred back and forth as the occasion arises. No one should be admitted directly to the custodial section without first having passed through the hospital section where every effort at rehabilitation should be made.

Chronic Hospital Last Refuge

In the filtration of patients through the various types of institutions that have been discussed, the custodial home of the chronic hospital is the final haven for those permanently disabled by illness, in whom the progress of the disease has been checked. It is the antithesis of the convalescent home. The latter is the stepping stone to full health, the former the last refuge for those permanently crippled by disease. The custodial home is a monument to the failures of medicine, and every inmate gives damning evidence of the insufficiency and incompleteness of organized effort for caring

for the sick. The advancement of medical science, the improvement of public health knowledge and methods, and an adequate community program of caring for the sick and disabled must all tend to reduce to a minimum the need for custodial homes. Those engaged in the hospital field can best contribute toward this end by envisaging the field of institutions for the sick in its broadest aspects, by learning that their own particular institution is but an element of a larger whole, and by striving for a proper balance between the many types of establishments for the sick, since it is to the hospital and health worker that the lay public must look for leadership in combating disease.

ANCIENT HOSPITAL EMPLOYS "MODERN" THERAPEUTICS

The account of the visit of Surgeon Commander H. M. Braithwaite, R.N., to the Amphiaraon, as published in the *British Medical Journal* for December 26, 1925, p. 1239, is stimulating to the imagination of the modern hospital worker.

The Amphiaraon is a temple-hospital near Oropos Skala, Attica, Greece, in a narrow valley surrounded on three sides by well wooded heights, and having in its center a deep gorge containing a small stream. Considering the antiquity of this hospital, which was erected about 900 B. C., it is in a surprisingly good state of preservation. There are hot baths, a colonnade 100 yards long and 5 yards wide, closed to the north and open to the south, with a roof supported by numerous columns. This colonnade was called the Stoa and contains marble seats. Close to it is a theater with marble seats arranged in tiers around the semicircular cutting in the hillside. In front are five chairs dedicated to ex-priests of the temple. In the theater is a white marble statue of Amphiaraos, the soldier-priest who founded this hospital at the site of a sacred spring.

Five Altars Dedicated to Gods

The temple contains five altars dedicated to a multiplicity of gods, goddesses, and demigods. The sacred spring is approached by a flight of ten steps. Behind it is the hospital and, to one side, a row of twenty rooms for in-patients. On the other side is a hall for out-patients, a cook house and numerous small rooms, apparently for the hospital personnel.

Several tables of stone have been discovered at this site inscribed with the rules and regulations of the hospital, as, for example: "The Temple is in charge of the High Priest of Oropos. . . . He must visit it at least ten days every month, except at ploughing time (that is, four winter months) . . . He keeps the key of the money chest. The house governor lives in the hospital . . . He must issue a ticket to every patient for admission, who must pay a fee of nine Obola and caution money five Drachmas. He must put the money in the Chest . . . He must keep good order, see that the treatment prescribed by the Priest is carried out, keep the men and the women separate . . . The left shoulder and the skin of Sacrificed Animals belong to the Priest."

From inscriptions and fragments, it is known that surgery, hydrotherapy, massage and suggestions were employed at this hospital, from the earliest times, as therapeutic agents.

MEETING INDUSTRIAL AND COMMUNITY NEEDS

By R. L. McCarrell, President, Board of Trustees, Washington Hospital,
Washington, Pa.

WITH the laying of the cornerstone of the Washington Hospital, Washington, Pa., on November 1, 1925, the first definite and concrete results of a long campaign for better hospital facilities were realized by the community to be served.

Washington is a thriving city an hour's ride from Pittsburgh and is in the heart of the mining and steel industry district. Previous to the campaign for a larger institution, Washington and the surrounding territory was greatly underhospitalized. A small city hospital had merged with the older Washington Hospital, and the general institution was attempting to serve the community, although hampered by inadequate facilities and quarters.

Service for Emergency Cases

The necessity of providing hospital service for the industrial concerns as well as the regular cases was the determining factor in the campaign for a new and thoroughly modern structure. The improvement of transportation facilities through the construction of new roads had made Washington accessible to a wider territory in the vicinity and proved that the opportunity was present for the inception of a campaign. Emergency cases from the mines and manufacturing industries de-

manded an adequate hospital since none of the concerns provided hospital facilities nor were their first aid facilities of the best.

Realizing the urgent need for such services, a number of citizens met to lay the foundation for a new and larger hospital. Committees were formed and definite steps were taken to launch a campaign for funds. The program was carried to every club and association in the community with the result that the first drive for \$500,000 was oversubscribed by \$18,000. With such gratifying results, the initial committee took steps to purchase property for the hospital site.

A plot of ground on the outskirts of the city, situated on an eminence that commanded a view of the entire county was selected, although it necessitated the additional purchase of an adjoining plot because of the presence of coal beneath the land originally purchased. Having secured the ground, the committee placed the project in the hands of the architects with instructions that the finished building be in harmony with the architecture of other structures in the city. This necessitated a combination of the Georgian and Colonial styles and presented a difficult architectural problem because of the sloping terrain.

At the present time a four-story fire-resistive structure, consisting of a central portion and two

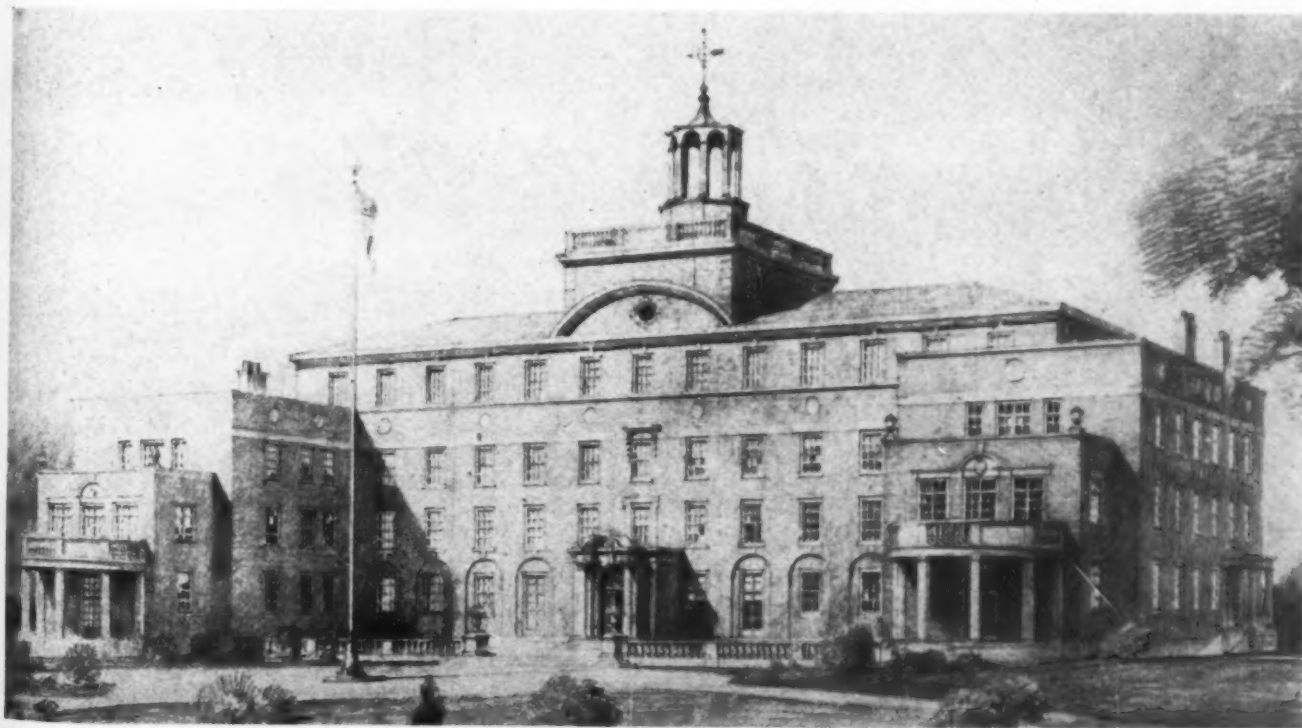


Illustration by courtesy of Richard E. Schmidt, Garden & Martin, Chicago
The new Washington Hospital, Washington, Pa.

wings, is gradually assuming shape on the hospital property. The building will have a capacity of approximately 150 beds, which, though a decided increase over the old institution, is justified by the demand for service by the community. Future expansion has not been forgotten and all service facilities have been planned with the idea of possible enlargement, while the property is large enough to allow for the addition of other buildings.

An inspection trip through the building as far as construction has been completed will serve to

On the northeast side of the corridor, across from the superintendent's office, are the superintendent of nurses' office, the record room, record locker room and men's toilet. On the same side of the corridor beyond the elevators are the cystoscopic room, dark room, radiographic room, operator's room and fluoroscopic room. The northwest wing includes three four-bed rooms, isolation room, utility room, a five-crib room and three-crib room, with infants' bath between. The children's playroom fronts upon the wing porch.

The southeast wing is devoted to the out-

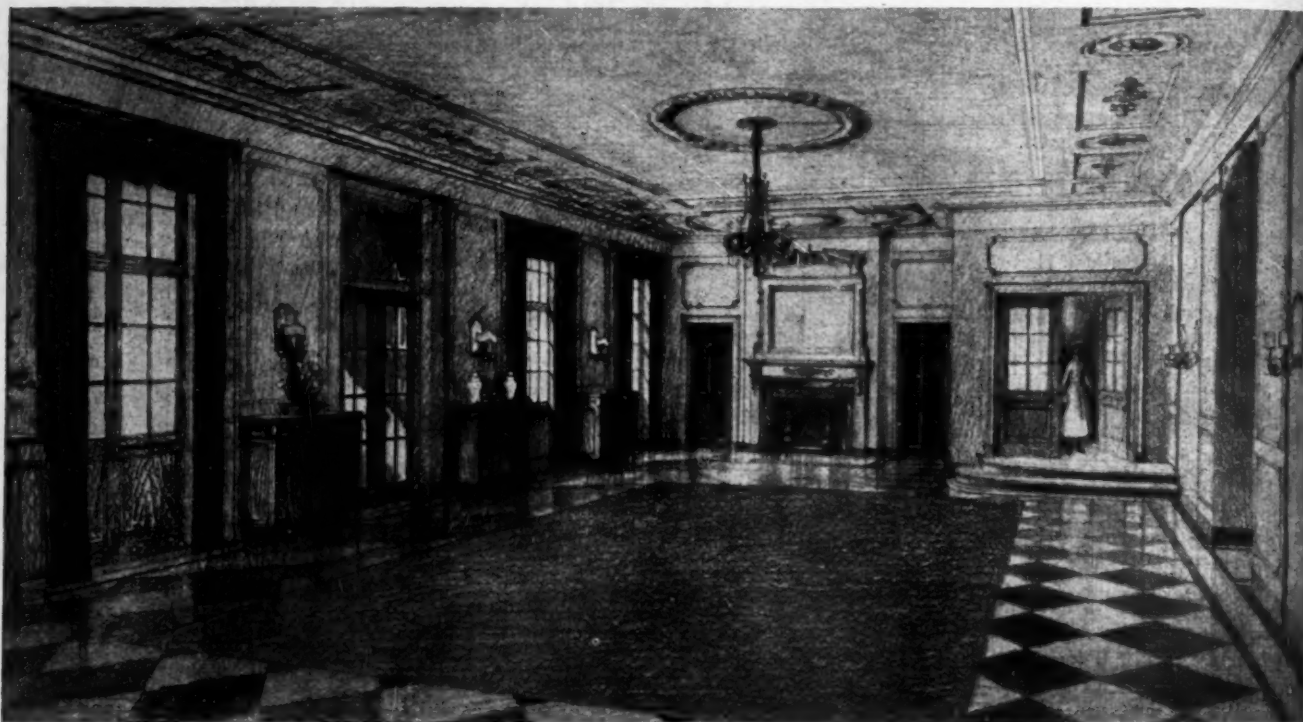


Illustration by courtesy of Richard E. Schmidt, Garden & Martin, Chicago
Attractive entrance lobby, showing appointments and arrangement.

point out many interesting features of the new hospital.

The entrance is approached by a winding drive through spacious grounds. A terrace extending the length of the central portion of the building is crossed and the vestibule and main entrance lobby is entered. This room, which will be furnished by civic organizations, is of spacious proportions and will aid in creating a favorable impression.

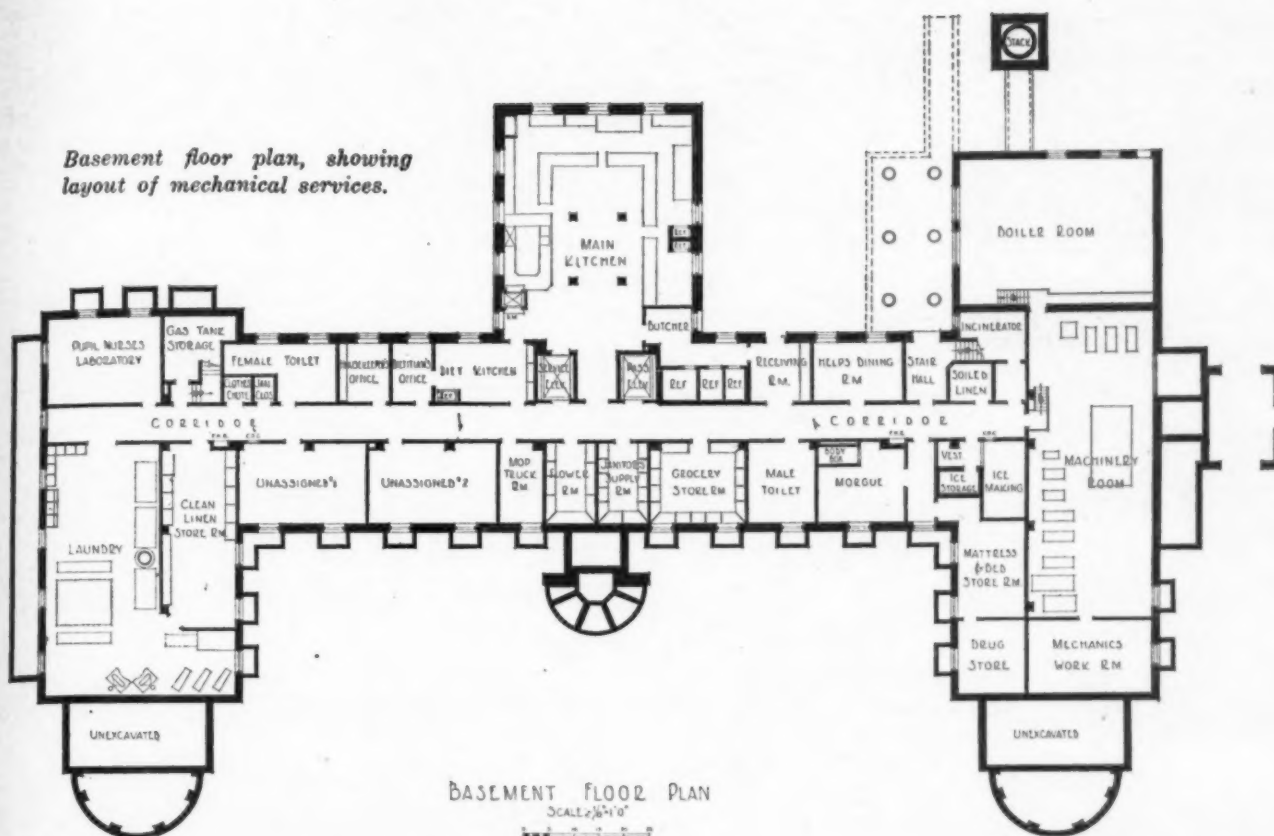
To the right of the lobby are the reception room, office, intern's laboratory and bacteriologic and pathologic laboratory, while the general office and superintendent's office are at the left. Directly across the corridor from the lobby are the passenger and service elevators and beyond is the service wing, which includes a locker room, nurses' dining room, staff dining room and a serving pantry.

patient and emergency services. The media and sterilizing room, chemistry laboratory and pharmacy are found on one side of the wing with the social service room, two treatment rooms and an emergency operating room across the hall. The waiting room for out-patients is entered from the wing porch. The ambulance entrance is adjacent to the operating room and the emergency room is across the main corridor next to the viewing room and doctor's office. Beneath these last named rooms is the boiler room and power plant.

Operating Suite on Second Floor

The second floor is devoted to private and semi-private rooms, each with separate toilet facilities. The northwest wing is given over to the operating room suite and is composed of two major operating rooms with a scrub-up room between, a minor operating room, instrument and

Basement floor plan, showing layout of mechanical services.

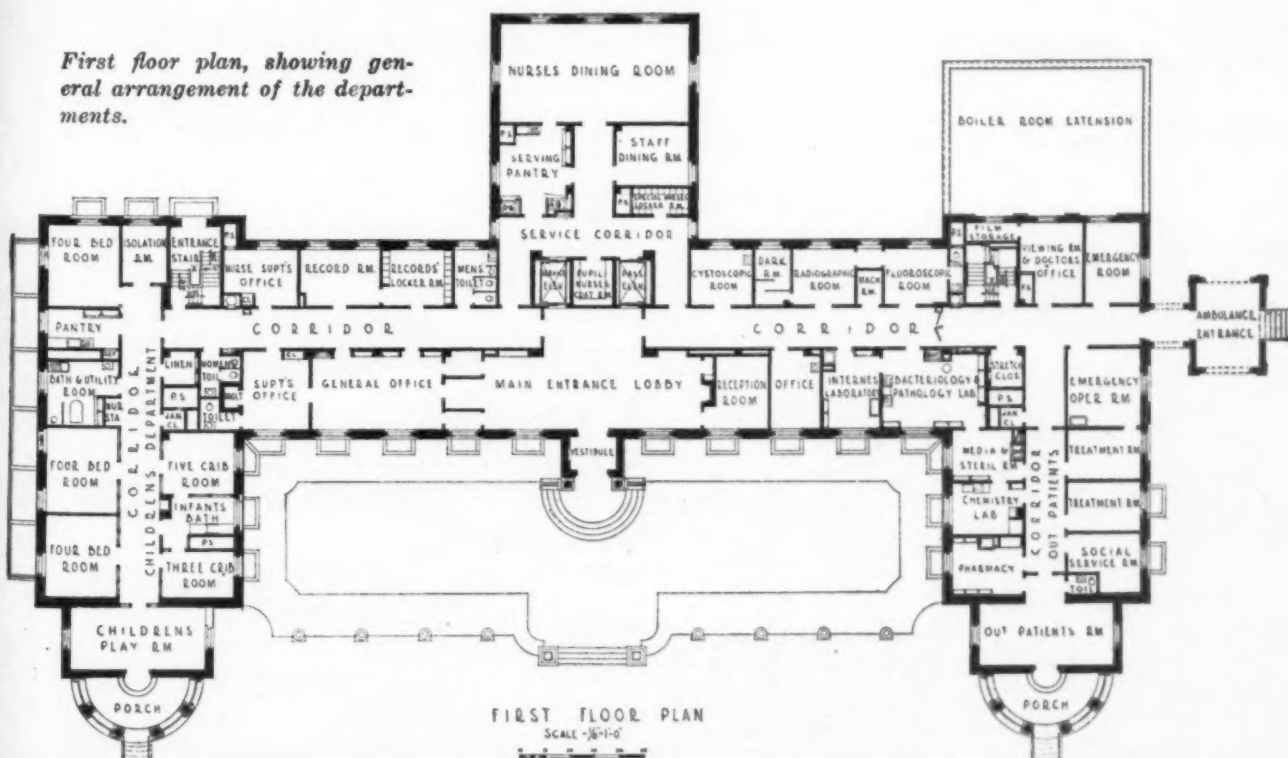


emergency laboratory, nurses' office, utility room, workroom, sterilizing room and doctor's lounge, rest and locker rooms.

The third floor is similar to the second, but is intended primarily for maternity patients. The

northwest wing is devoted to labor and delivery rooms, with such necessities as a "husband's room" and preparation and utility rooms, while the remainder of the floor is planned for private room service. The fourth floor is for private

First floor plan, showing general arrangement of the departments.



Illustrations by courtesy of Richard E. Schmidt, Garden & Martin, Chicago

patients only and includes two *de luxe* suites. This floor occupies only the central portion of the building as the roofs of the wings are devoted to solariums and promenade roofs.

The ornamental tower which surmounts the central wing houses the machinery of the elevators and dumb-waiters and ventilating fans, and provides facilities for the intern's living and sleeping quarters.

The basement floor, a portion of which is unexcavated, houses the laundry, main kitchen, diet kitchen, dietitian's and housekeeper's offices, boiler room, machinery room, student nurses'

through the use of a vestibule that eliminates traffic noises from the floors. Here is also located the nurse's station, where the attendant may command a view of the entire corridor.

Terrazzo is used for the flooring and floor bases throughout the structure and the operating rooms and birth room are finished in pale green.

In the labor room and major and minor operating rooms clocks are installed, the mechanism of which lightly rings a bell every fifteen seconds, allowing the doctor to note changes in condition without removing his eyes from the patient.

Most of the basement is above ground because of the slope of the plot. Lighting facilities are therefore of the best and excellent working conditions for the help are provided. Likewise, because of the slope of the ground and the hospital's conspicuous location on a prominent hill, the architecture of the build-

Second floor plan, showing operating room suite.

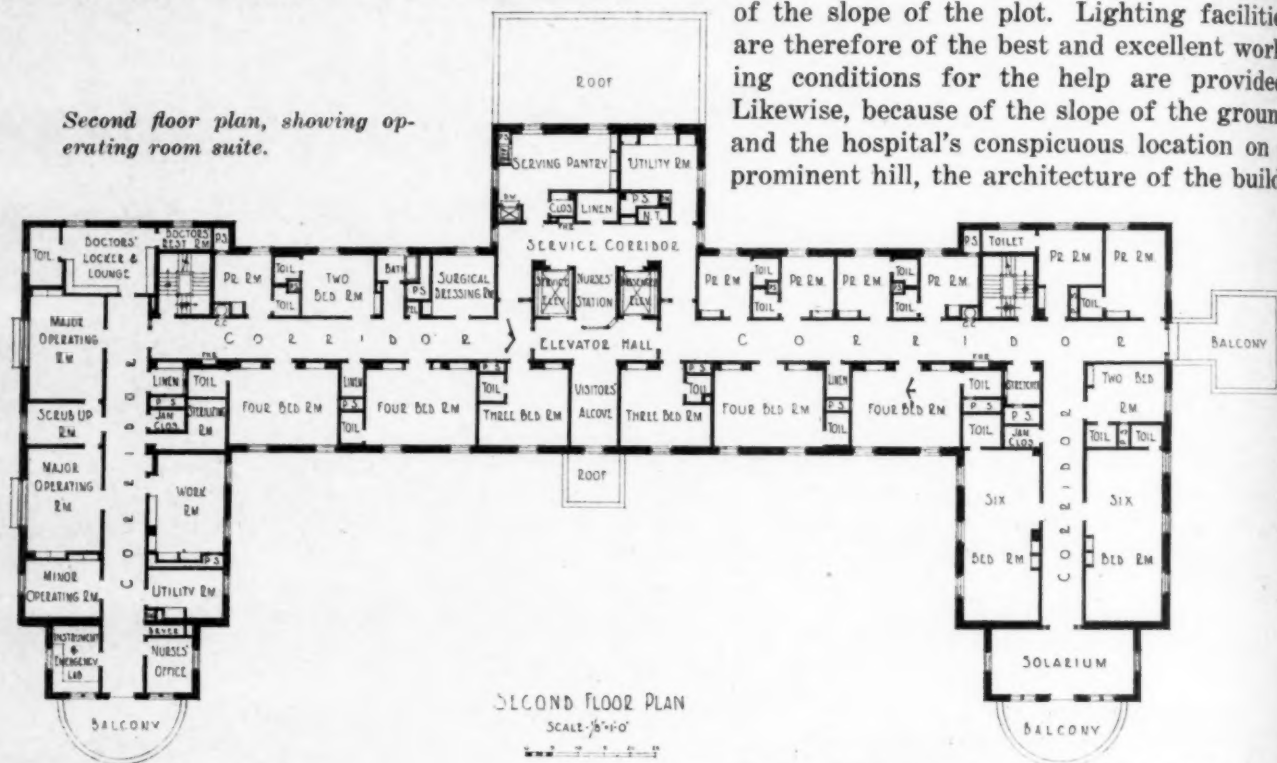


Illustration by courtesy of Richard E. Schmidt, Garden & Martin, Chicago

laboratory, morgue and storerooms. The help's dining room, various workrooms and the incinerator are also in the basement.

Among the many items of interest in the building are built-in sterilizers and cabinets, conduits for the transmission of high voltage to the patient's bedside and the use of sound-absorbing material throughout the hospital. High pressure steam will be used in all sterilizers and instead of an ammonia system of refrigeration, CO₂ will be used in order to mitigate the possibility of explosion and obnoxious odors caused by pipe breakage.

Individual toilets are provided for each room. The *de luxe* suites are located at each end of the fourth floor. These rooms are larger than the other private rooms and offer a private bath, shower and alcove.

The elevators are shut off from the corridor

ing has been treated in the same manner from every angle, equal attention being given to all sides of the structure.

To enhance the beauty of the wall, the textured brick is laid in alternating rows of headers and stretchers so that an indefinite diagonal line is created. The flanking wings are practically devoid of ornament of any kind, the circular stone porches at the ends serving a useful purpose.

The central portion, rising one story higher than the wings, has a strong stone cornice and a hipped roof of rough texture slate. The central feature, the ornamental tower, made of brick, stone and copper, rises 110 feet above the ground.

The hospital, situated in spacious grounds, lends itself admirably to the art of the landscape architect, and the arrangement of shrubbery, walks and drives will be in perfect harmony with the character of the building.

HOW WORKMEN'S COMPENSATION AFFECTS THE HOSPITAL

By John A. Lapp, LL.D., Director, Division of Social Action, National Catholic Welfare Council, Chicago

THE care of injured workers has always been the work of the Good Samaritan; the injured make a universal and special appeal to our charity. The spectacular character of injuries and the sudden and complete affliction upon the injured worker call for instant outpouring of sympathy and the extension of immediate relief. In this the most immediate response comes from the medical profession and hospitals. The injured must be saved and no one stops to question the extent of the means necessary for immediate care and restoration. Medical aid and hospital facilities are put at the disposal of injured workmen without thought of race, creed or condition in life. Without any laws or public agencies looking to that end charity would do what it could.

We have a condition, however, resulting from a long trend of legislation, which culminated in the workmen's compensation acts beginning in 1911, that has changed the entire relationship of the injured patient to the medical profession and hospitals. It is essential that this changed relationship be understood minutely in order to safeguard the charities of the hospital and give effect to the laws. A full understanding cannot be had without a review of the trend of legislation which has brought about the new situation. There are three separate stages in the changing relationships of workmen to their employers with respect to injuries. In the olden days under the common law, an injured workman might sue his employer for damages, but if it were shown that the injury was caused by the act of a fellow-servant, or if the workman

contributed to his own injury, or if it were shown that the workman had assumed the risk of the occupation, no recovery was allowed. Such was the situation down practically to the beginning of this century. With the three limitations in force it happened rarely that a workman could actually secure damages for injury in

the course of employment. Having slight resources and being deprived of ability to work, the workman was necessarily dependent upon charity. In such circumstances the charity burden fell first upon the physicians and in the more serious cases upon the hospitals in which the injured patients were sent for treatment.

The evident injustice of this system led to the enactment of employers' liability laws in the latter part of the last and the earlier part of this century. The changed industrial conditions from the small plant, and from the mutual relations of master and servant of the middle of last century, to the great industrial enterprises, the

Where the Burden Falls

IT should not be assumed, however, that the ideal system of workmen's compensation has been adopted everywhere; nor should it be assumed, however, that this ideal system has been carried out anywhere in absolute perfection. In the first place the laws of several of the states so limit the cost of medical and hospital care as to make the provision nugatory. For example, a state that provides for medical, surgical and hospital attention for a period not less than two weeks and not to exceed seventy-five or one hundred dollars in any case, lifts little of the burden of charitable care from the hospitals. Such a provision takes care of the minor injuries only, but is hardly sufficient in more serious cases to pay the necessary medical and surgical attendance, thus leaving the hospital in the lurch.

extended transportation system and corporate organization made the fellow-servant rule and the assumption of risk and contributory negligence farcical so far as justice to the injured worker was concerned. The new laws sought to remove these three defenses from the employer and to place upon him more directly the cost of injuries to workers in his employ.

While beneficial to some degree, these laws did not materially change the situation. An injured workman had generally to sue for damages. After a prolonged trial he might or might not secure compensation for his loss. If he secured

it, a large portion, usually a half, went to the attorneys who handled his case. In any event, he had no income from the time of the injury to the final decision of his case a year or more afterward. During the interval he had to have medical and hospital attention. So far as the hospitals were concerned there was little change from the previous condition. Injured workmen were in the main objects of charity for their hospital service. Those who succeeded in collecting damages from the employer might eventually pay, but the actual returns were small.

Passage of First Bill

Such was the condition when the idea of workmen's compensation for industrial accidents was formulated in the State of New York and enacted into law in 1909, but postponed in operation because the first law was declared unconstitutional by the high court of that state. The first actual permanent act was that of New Jersey, passed in 1911 and signed by Woodrow Wilson, then governor of that state. Since that date laws have been enacted in all but four of the states of this country, the latest being that of Missouri, passed in 1925, although held up for a referendum vote until the fall election of 1926.

Theory of Compensation Act

The theory of the workmen's compensation acts is that the cost of accidents should become the burden of industry by an equitable arrangement fair to all concerned. The employer is made liable for all injuries occurring in the course of employment. The employees gave up the right to sue for damages in return for fixed payments in proportion to wages and the cost of medical, surgical and hospital attendance. In a few of the states this system applies to all employments except agriculture and domestic service; in others it applies to all employments, with the two exceptions above, provided the employers and the employees have not elected to stay out of the system.

In practice the compensation laws now apply in most of the leading industrial states to practically all employments, except agriculture and domestic service and the interstate railway workers who are not subject to the state laws and for whom no national act has yet been passed. The system applies in the main to all employees of state and local governments, unless otherwise provided, and a national law has been passed applying to all federal employees. Seamen are not included, and by a technical decision of the court, longshoremen and other harbor workers are excluded from the benefits. The great bulk of the

workers of the country are included under the compensation laws.

Two distinct benefits are provided for the injured workmen—cash benefits and medical and hospital care. A third benefit—vocational rehabilitation—is gradually being extended. To the hospitals the change in the workmen's compensation was most significant. Injured workmen, to whom the law applied, were no longer in need of the material charities of the hospital. They became pay patients, the law specifically putting the cost of medical and hospital care in most of the states upon the employer. The employer, in turn, insured himself against the risk of loss either in an insurance company, a state fund (the term applied to insurance by the state) or, if large enough and financially able, the employer, if approved by the commission, could carry his own insurance. The important consideration was that the workman did not have to ask charity or depend upon the precarious results of a suit for damages. The law specifically gave him the right, without any action on his part, to the cost of his medical and hospital care from his employer or the insurer of his employer. The hospitals retained their personal relations with the patient, but the economic relations were with the employer or the insurance carrier. The hospitals no longer looked to the patient for compensation or needed to extend to him its charity. The employer had become legally responsible and it was to him that the hospital could turn, not in appeal but in distinct right for the payment of the hospital bill of persons injured in their employment. If, then, the hospital extended free service or part-pay service to such a patient it was not extending its charity to the patient but to the employer or the insurance carrier who was liable for his care. If the hospital wished to extend charity to the employer or to an insurance carrier, it might do so, but it ought to do so with a full understanding as to who received the charity.

Some States Have Ideal Scheme

The ideal scheme as developed in a few states has been to provide for the temporary or permanent losses of the injured workmen in the case of permanent disability extending sometimes throughout life, and for medical, surgical, hospital and nursing attention without limit, although in several states if the costs are to exceed a certain sum, approval must be secured from the state commission.

It should not be assumed, however, that this ideal system has been adopted everywhere, nor should it be assumed that it has been carried out anywhere in absolute perfection. In the first

place, the laws of several of the states so limit the cost of medical and hospital attention as to make the provision nugatory. For example, a state that provides for medical, surgical and hospital attention for a period not to exceed two weeks and not to exceed seventy-five or one hundred dollars in any case, lifts little of the burden of charitable care from the hospitals. Such a provision takes care of the minor injuries only and is hardly sufficient in more serious cases to pay the necessary medical and surgical attendance, thus leaving the hospital in the lurch. The injustice of this limitation is evident when we take a simple and frequent case of a serious injury involving three months, let us say, of hospital care. The workman is injured and is immediately taken to the hospital. He is cared for for two weeks and the paltry seventy-five or one hundred dollars which is allowed is barely sufficient to pay the physician and the surgeon. When the two weeks are up and the money exhausted, what is the recourse? The hospital cannot put such a patient out of doors and yet there is no money under the law to pay the bill. Under the guise of workmen's compensation this heavy burden is shifted to the hospital to take care of the injured person as a charity patient, while the employer and the public assume that under the compensation law justice has been done to all concerned.

Full Service Less Costly

Such a policy is indeed short-sighted. Anyone who is acquainted with the values of adequate medical, surgical and hospital attention knows that the most economic way to handle an injured case is to provide adequately for these services. The states that have given reasonably complete medical, hospital and surgical services have found that the cost is after all so slight as to make but a small difference in the cost of the compensation system. There can be little doubt but that if the shortened periods of money compensation were taken into consideration, the total cost of compensation would actually be lessened. At any rate, it has been proved that complete care can be given without danger of overburdening the compensation system.

Another question directly related is that of the actual amount of payment for the hospital services. What should the hospital charge? Obviously, since it is not a charity to the workman, the charge should be enough to pay the cost, at the very least. No hospital has a right to sell its services to employers or insurance carriers for less than the actual outlay in their behalf. This will be obvious when the subject is disentangled from the idea that the material charity of the

hospital is extended to the injured workman. It is not easy to do this because it is not easy to separate the true spirit of charity from its material aspects. Hospitals should, of course, give charity in its true sense. No hospital should exist which would not do that, but on the material side of the charity it is a business proposition between equals, an employer or an insurance carrier, on the one hand, obligated and able to pay for the care of the injured worker and, on the other, the hospital which supplies facilities largely out of benevolences. In the protection of such benevolences the hospital owes a duty to the benefactors to use the funds in their care for charity where charity may be necessary, but not to use them in behalf of those who are able and liable to pay for the service rendered.

Are Hospitals Fully Paid

Do the hospitals at the present time receive the cost, under the compensation systems, for the care of injured workers? The facts are not all assembled and even if they were they probably would not give the exact story owing to the difficulty of determining the exact costs. General data indicate that the hospitals do not receive the cost of service under the workmen's compensation laws. In a compilation covering forty-two hospitals from a large number of states, it is disclosed that the average payment for workmen's compensation cases is \$3.33 per day; eleven of these hospitals had a rate of \$2.50 or under; twenty-four had a rate of between \$2.50 and \$4.00; one had a rate of \$5.96; another, \$7.00, and a third \$7.56. These facts indicate clearly that some hospitals are not charging or are not receiving the necessary costs. Moreover, the information gathered came from the more strongly organized hospitals which would be in a position to secure fairer treatment. Many other hospitals, weaker in resources, not included in the tabulation, would not have fared so well even as these.

Examination Shows Contrary

That the hospitals in the main are not receiving the cost of service rendered, and are thus extending their charities to corporate interests capable of paying and liable under the spirit if not the actual provisions of the act, is evident from the most casual examination of the facts available to any one. That this ought not to be the case should be clear to hospital superintendents and managers and to industrial commissions. The excuse is often given that a lower rate is provided for certain corporations because of the benefactions to the hospital on the part of such

corporations. This excuse results from a clear misconception of the whole relationship of hospitals under the workmen's compensation laws. Before the laws were passed corporations gave what they called benefactions, but it was understood, tacitly, at least that service would be rendered to their employees. That was before liability was put upon the employers. When such liability was put upon them their gifts could no longer be payments for service rendered. If they were gifts, then they did not cover compensation payments; if they were payments to cover the cost of liability for hospital service, they were not gifts. At any rate, the transfer of the liability by most employers to the insurance companies changed more completely the relationship.

Another confusion which has resulted is found in the use of public hospitals for the carrying of the burden which the compensation laws put upon industry. County, city and state hospitals have been used to provide medical service free of charge. Before the compensation laws this was a charity to the individual given by the community. After the compensation laws were enacted it became a gratuity to the employers or the insurance carriers. If the principle of workmen's compensation acts is to be fulfilled, public hospitals must charge the full cost of their service in the care of injured workmen who come under the compensation systems.

Line of Action Clearly Evident

The foregoing resumé indicates a clear line of action for the hospitals, their legislative committees and associations. That line of action is to work unceasingly to get established in practice, in laws and commission rulings the fundamental principles underlying the compensation laws. The most fundamental of these principles is that the workman should receive what the law implies, namely compensation for losses. Even at best, the workman must stand a large portion himself. It is a fair estimate to say that even under the best organized compensation laws, the workmen, on an average, still bear at least fifty per cent of the cost of their injuries. They usually lose from one to two weeks at the beginning as a waiting period, and they never receive more than two-thirds of their wages, more often less than half.

Hospitals should make intensive analyses of the provisions of the acts in their respective states and should secure the enactment, in common with the medical profession, of laws which would provide for completely adequate care for injured men and for fair compensation, at least equal to the cost thereof, for the hospital service rendered. Moreover, the hospitals being in a bet-

ter position to see the advantages of rehabilitation, should extend their influence to the making of both physical and vocational rehabilitation a recognized part of the compensation system. In doing this the hospitals will be promoting fairness to themselves and to the public and will be advancing the high social purposes of the whole scheme of compensation.

HOW A SMALL HOSPITAL PROVIDED A ROOF GARDEN

Many small hospitals and not a few of the larger institutions make no use of their roofs because they are the tarred and pebbled type that do not lend themselves to open air rooms for wheel and rocking chairs.

The roof of the Aurora Hospital, Aurora, Ill., of that type of construction was altered for roof garden purposes at very little expense. The housing for the elevator sheaves and suspension beams was, of course, built at the time the hospital was erected. To provide a roof garden it was necessary merely to cut a door in one side of this housing, pave a portion of the roof with smooth tile and enclose the eight-foot area with woven-wire fence to keep the patients from going beyond this area.

This roof garden added at a minimum cost was much appreciated by the convalescents who now use the roof as a sunparlor.

ANOTHER REASON FOR KEEPING STATISTICS

We hear from many superintendents the complaint that the board of trustees has little conception of the administrative problems of a hospital and is unresponsive to suggestions for the advancement of service or the purchase of needed material. One administrator has remarked that there should be a "school for the training of trustees." Probably the "evil" of "trusteeship" is one that will be with us for some time to come. It is difficult, however, to see wherein the superintendent of a hospital should have a more difficult task in "selling" his board of trustees an idea or a deficit, than have presidents of large industrial concerns in controlling their boards. If the control of a board of trustees is a greater problem in a hospital than it is in an industrial organization, it is probably because the industrial executive has more accurate and complete figures and facts at his command.

WHERE SHALL THE LABORATORY BE LOCATED?

"Proper spacing, planning, airing, lighting and accessibility are desirable for the clinical laboratory," according to Dr. M. T. MacEachern of the American College of Surgeons in an address delivered before the fourth annual convention of the American Society of Clinical Pathologists. "Fortunately in recent years there is a tendency to depart from the custom of placing this department in the basement. It is generally agreed today that the clinical laboratory deserves as desirable a location as any other department in the hospital. Personally, I have been advocating its location in or adjacent to the operating room suite. The best location, however, can be selected by determining where contact will be afforded with the greatest number of the medical profession at all times."

SILENT CONTROL FOR THE PATIENT'S DOOR

By Charles F. Neergaard, Hospital Consultant,
New York

THERE is hardly a field in which the persistence of habit is so conspicuous as in that of the hospital. An outstanding example of this is the continued use of hardware on the patient's door, which, although it costs a great deal of money, utterly fails to do its job. The noisy latch, the hinges, the door closer, the floor stop, each one is a compromise.

The click of the latch as the knob is turned when the door is opened or closed is sufficient to spoil a much-needed nap. Its chatter against the strike as the door vibrates to the drafts is an intermittent annoyance that has banished sleep through many a long night. Nevertheless, for lack of something better hospitals persist in putting a latch on the patient's door and then rendering it ineffective by tying a bandage or rubber strip from knob to knob to silence it. The slam of a door, whether caused by a gust of wind or carelessness, is always a shock to the patient, be he critically ill or nervously convalescent. Yet we use ball bearing hinges which work so easily that slamming is unavoidable. To neutralize these, we put on a door closer, an expensive device that requires frequent adjustment. When it works it closes the door slowly and noiselessly, but never holds it tight shut. But the patient's door is kept ajar much of the time for ventilation. This necessitates counteracting the door closer by a floor stop to hold it part way open. Every known type of stop, whether spring controlled or otherwise, is usually noisy and always a nuisance to operate and maintain. All such stops depend on the grip of a rubber pad against the floor, which soon wears smooth, loses its elasticity, slips and scrapes an unsightly trail along the floor.

With the latch comes a lock, usually with a sep-

arate key for every door and a master key controlling all. For one hundred doors one hundred keys to keep track of! But why this expensive outfit? How often is a patient's door locked?

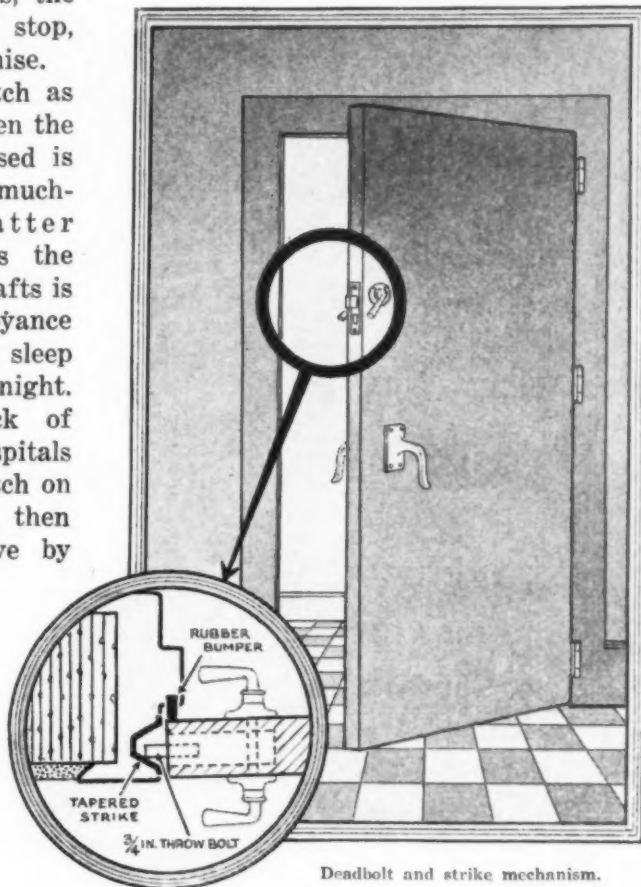
When we thus analyze the conventional patient's door hardware, which costs in the neighborhood of \$25 a set, we find we are paying a pretty stiff price when every item except the screws fail to do what is wanted.

For some time the writer, with the cooperation of a number of manufacturers,* has been experimenting to perfect a set of hardware for the patient's door which would really give satisfactory results. What are the needs? For the patient, quiet; for the nurse, simple action; for the management, minimum upkeep; for the building committee, good appearance and low cost.

All of these needs have apparently been met. First, by the adaptation of standard friction hinges which

control position and slamming; second, by the invention of a silent deadbolt and a tapered strike which effectively wedge the door against rubber bumpers let into the jamb and hold it fast against all vibration.

The Hinge: The friction hinge incorporates the principle of an easily adjusted metal brake band which may be set at any desired tension. A set of three of these effectively takes the place of the usual ball bearing hinges, the door closer and the floor stop. They prevent slamming and hold the door open at any point, unaffected by normal drafts. The friction hinge has been on the mar-



Deadbolt and strike mechanism.

*Appreciation is expressed to the following firms for their assistance: Norwalk Lock Company, P. & F. Corbin, New Britain, Conn.; Oscar C. Rixon Co., Chicago; Russell & Erwin Mfg. Co., New Britain, Conn.; Dahlstrom Metallic Door Company, Jamestown, N. Y.; Sargent & Company, New Haven, Conn.; Lawton-Stephens Company, Brooklyn, N. Y.

ket for a long time. Experience indicates that the friction feature will last for many years. The first cost of a set of these hinges is less than one-third of the combined cost of the ordinary hinges, the check and stop, which they replace. Their maintenance and adjustment will be infinitely lower and they will render service at less effort on the nurses' part. With friction hinges the door must be shut by hand, but the effort involved in the course of the day is far less than that required by the setting and releasing of the floor stop. For a wide patient's door the hinges should be set so that a pressure of seven pounds must be exerted to open or close it. This is two pounds less than the force required to move the same door against a door closer.

The action of the friction hinge subjects both the door and buck to considerable torsion strain, to meet which it is essential that all screws be longer and heavier than those normally used. Where metal doors and trim are specified the hinge reinforcement should be substantially stouter than is ordinarily used.

The Bolt: To replace the latch with a noiseless device that would give positive control under all conditions was a more perplexing problem and required fundamental departures from previous practices. It was realized that a door newly hung by the builder did not represent normal conditions, as after a period of service it is subject to many variations of alignment, shrinkage, warping, swelling and sagging, all of which must be anticipated and provided for. In addition rubber bumpers will lose their elasticity in course of time and if not promptly replaced will be ineffective and allow play which means noise.

Positive Cam Action Deadbolt

The device finally adopted after many models had been tried and rejected was a deadbolt which is thrown by a simple, positive and noiseless cam action, controlled by lever handles on either side of the door. The deadbolt has a three-quarter-inch throw, approximately one-third greater than usual. This feature was difficult to achieve mechanically, but is essential for taking care of all possible variations. To receive the deadbolt a trough-shaped, tapered box strike was designed. The deadbolt pressing along the tapering sides wedges the door against two simple, soft rubber bumpers let into the trim and holds it fast. The strike is set so that at the start the dead-bolt meets it with a quarter turn of the handle, an additional quarter turn being in reserve to control future variations. This at all times insures tight contact between the door and the bumpers.

The human element had to be considered. When we take hold of a knob we instinctively turn it

to release the latch. If the deadbolt is turned when the door is open it will, on closing, strike against the trim and mar it, also jarring the lock. To prevent this the bolt is set five feet two inches above the floor, considerably higher than the normal knob, so that it will be used only with conscious effort. An arm hook is placed on either side of the door to serve as a handle. In modern hospital practice these have proved indispensable to facilitate the nurse's opening and closing of the door when carrying a tray. The hooks are set inverted with the points thirty-nine inches above the floor. That on the push side is placed ten inches back from the edge of the door so that the elbow will not strike the trim.

Bumpers: Simple rubber bumpers have been designed which where metal trim is used are inserted through a hole punched in the stop. With wood trim they are screwed on. The cost is nominal so that they can be replaced whenever the rubber loses its elasticity.

The Lock: Experience indicates that there is no necessity for a complicated lock on a patient's door. The key is never used on the inside and but rarely on the outside—when the room is vacant, when the patient has died, or when redecoration is in progress. These requirements obviously do not warrant the expense of a different lock on every door, with the consequent complication of many keys to keep track of. A simple, single tumbler lock has been adopted with key-hole on the outside only, controlled by a single key which will open all patients' doors, and of which each floor supervisor will have a duplicate. This in itself results in a material saving.

After many months of study and experimentation this special noiseless patient's door hardware is now being manufactured and has been specified for a number of new hospitals whose architects and building committees have carefully analyzed its every feature. It meets, apparently, all of the prerequisites established, in quality, cost and service. It will be acceptable equally to the wealthy institution which demands the best irrespective of price and to the smaller and less affluent one, which, because of its low cost, cannot afford not to use it. This is one hospital specialty which differs notably from the usual special hospital equipment in that it costs only half, instead of three or four times as much as the standard article which it replaces.

Among the nations of antiquity the Greeks and Romans have done the chief work in the field of public hygiene. Many Greek statesmen and philosophers occupied themselves earnestly with hygienic questions and proclaimed the principle that it was the duty of the state to provide for the health of the people.

THE HOSPITAL AS A PUBLIC HEALTH AGENCY IN PREVENTIVE MEDICINE

By R. G. Leland, M.D.,
Toledo, Ohio

FEW subjects, if any, are so deeply interesting to man as that of the duration of human life. The sciences of biology, medicine and hygiene have been developed with the fundamental purpose of revealing the underlying principles of vital processes so that ultimately it might be possible to prolong the length of life to the maximum number of years of modern times.

For a number of decades the chief object, and in some instances the sole purpose, of certain groups of individuals has been so to influence community and individual conduct and responsibility that sickness and death from preventable causes might be reduced. This effort, in most instances, has been carried on almost independently of the curative work.

Within the past few years, it has been shown that, to produce the best results, curative and preventive measures cannot be wholly dissociated. The present "health positive" program has displaced the "get well if you can" attitude and the curative measure is fast becoming the court of last resort, having been displaced by the sensible resolve to stay well.

There are but two classes of our population who can now afford to be sick—the indigent and the well-to-do. Philanthropic societies and clubs, community chests and state laws make it possible to care for the former, and the latter are able to provide for themselves. It is, then, for the vast middle class, that constitutes the majority of our population, whose assets consist of pitifully meager wealth together with abundance of self respect, that illness is a burden.

Now, because of their meager monetary means both the middle class and the indigents are oftentimes unable to provide for themselves many of

those necessities of life which we believe are essential to continued good health. Furthermore, those factors that contribute toward ill health eventually also contribute toward unemployment, inability to provide clothing, food, lodging and education. Thus the individual becomes ever more financially burdened and the problems of health, finance and even existence form them-

selves into a widening, vicious circle demanding increasingly greater community courage and investment to break the ring.

To be sure, during the past several centuries, institutions answering to the various designations of hospital, asylum, almshouse, home or retreat, have been established to care for the sick. At first and until recently these establishments were solely for curative or relief purposes. However, in keeping with our modern advancements in education, medicine and social development, the establishment that we

A Factor in Health Promotion

THE modern hospital should be not only a haven for the sick and injured, but also a factor in health promotion, and as an agency seeking to prevent suffering and unnecessary and premature death the hospital should be closely allied to the periodic health examination movement.

The hospital occupies a strategic position between the medical profession and the public. It has open to it a great opportunity and a correspondingly great obligation, not only as an institution for the salvage of human wreckage but as a coordinator of professional, economic and social activities in their application to the problems of health.

now know as a hospital, and which may be defined as "any institution, public or private, for the reception and care of persons for a continuous period longer than twenty-four hours, for the purpose of giving advice, diagnosis or treatment bearing upon the physical or mental health of such persons," must now become actively engaged in a new field, that of preventing illness and prolonging life.

It should be obvious that the medical or social system that is conditioned by destitution can never become a preventive system. It necessarily deals with the end products of existence and disease. It never has to face life and disease for their own sake, it deals only with individuals and disease as incidents. Such a system concerns itself with subsistence rather than fitness.

Unfortunately many institutions or hospitals that care for the inefficient, the derelict or the indigent are managed along the lines of economy rather than of service.

It should be clear that in some respects our system of hospitalization either must be recast or must accept the challenge to provide adequately for every class of sickness. Nor is it enough that it be prepared to care for every type of disease that may be presented for treatment. The community must understand that both the treatment and prevention of all disease and disablement must be provided for in an appropriate way, and among these methods hospitals occupy the first place.

At present the public appreciates the hospital simply as a place where the sick or injured are given medical attention, and as yet little has been done to demonstrate to the patients and to the public the potential health powers within the hospital.

Hospital More Than Haven for Sick

The modern hospital should be not only a haven for the sick and injured, but also a factor in health promotion, and as an agency seeking to prevent suffering and unnecessary and premature death the hospital should be closely allied to the periodical health examination movement.

The health examination is a thorough physical and mental appraisal or inventory to detect physical impairments and faulty habits of personal hygiene. Such an examination, properly done, will reveal defects and will indicate remedial measures.

Sanitary science has achieved notable conquests over many of the communicable diseases and has succeeded in cleaning up environment and making it reasonably safe. But, as yet, little success has attended our efforts in dealing with those diseases that are of a purely personal nature—the organic diseases. A decrease can be shown in the prevalence and severity of certain diseases, notably small-pox, typhoid fever, malaria, diphtheria, yellow fever and hookworm disease. But the incidence of nephritis, heart disease, cancer and other diseases of middle age and adult life appears to be gradually and undoubtedly increasing.

Early diagnosis is one means by which this mounting mortality may be influenced and the already falling death rates may be further reduced. Without this early, accurate and complete diagnosis it is impossible to apply the treatment that is necessary to hinder or prevent the development of the disease.

What is true of the organic diseases is equally

true of tuberculosis, syphilis, dental defects and focal and other infections.

Although the plan for the periodic physical examination is one in which the primary object is a more frequent consultation between patient and physician, the hospital may, under certain conditions, take an aggressive part in such work, particularly by requiring that all the personnel of the hospital comply with this plan.

Should all this be accomplished, there is yet something profoundly wrong with the system. The out-patient and in-patient departments of a hospital are too often dissociated. The dispensary or out-patient department may feed the hospital proper, but there is no true intellectual continuity between the incipient and the ultimate diagnosis. It is to the out-patient department that the early cases come, but it is to the hospital proper that the men with the highest skill and widest experience in diagnosis and treatment gravitate. It must therefore happen frequently that the incipient case is missed when the chief of the out-patient department does not have the proper relations with the house staff or has insufficient experience in the recognition of incipient cases. There is ample opportunity in the out-patient departments of hospitals for the correlated investigation of subjects by the house staff. It is not right to reserve the highest medical skill for the chronic and incurable cases of heart, kidney, lung and joint disease, and leave to the junior and student men the incipient stages of the same diseases. It is at the beginning of a disease that the highest skill is needed, for it is then that it counts most. It is for the benefit of the patient and the good of the professional staff that the out-patient as well as the house staff be composed of both senior and junior practitioners.

Case Handling System

Sir James Mackenzie has in a very vivid way called attention to the topsy-turvy manner in which the medical work in hospitals is conducted, pointing out that, when disease is in the earliest and most curable stage, when it is most difficult to detect and therefore requires the most experienced physicians to detect it, patients are sent to the out-patient department and left to the least experienced members of the hospital staff. On the other hand, when the disease is most advanced and often actually incurable, and when symptoms are easiest to perceive, the patients are admitted to the wards and placed under the care of the senior and most experienced physicians. He points out also that patients whose symptoms were purely subjective have been seen repeatedly presenting themselves to the out-patient depart-

ment where their trouble was unrecognized and whence they were sent with a bottle of medicine and instructions to return if they were no better. These patients kept returning until the disease was sufficiently advanced to show physical signs, after which, but not before, they were considered fit for admission to the hospital.

If hospitals are to serve the ends of preventive medicine the out-patient department must be placed on an equal footing with the hospital proper. Much indigency would be prevented by the elimination of chronic and preventable diseases, therefore the hospital that discovers and corrects disease in its incipency will contribute much to the community welfare as well as to the reduction of the general morbidity and mortality.

Annual Health Examination

The attitude of the hospital toward its personnel should be consistent and, prompted by concern for the health of its own people as well as by the resolve to establish a worthy precedent, every hospital should require an annual health examination of all its employees.

It must not be inferred that hospitals may discharge their duty to the general public health program by adding to the type of work already done an activity pertaining more closely to health promotion. The hospital is a private corporation filling a positive public need. Its sole function is to promote public health, and the difference between efficient and inefficient hospital performance is the difference between sickness and health, between life and death of human beings. Moreover, hospital functions embrace activities beyond the scope of medical and nursing practice and, independent of all medical service and the most that accomplished nursing can do, these additional functions affect the patient's chances for recovery. Medical and nursing service may be given in the home, but the seriousness of a case demands its removal to the hospital. It is those facilities and activities constituting the difference between home and hospital care that differentiate between medical practice and hospital performance.

If we agree with the council of health of the American Medical Association that the future of curative and preventive medical practice depends upon providing such hospital, laboratory and dispensing facilities, supported by the public, as will permit the application of modern science in a way impracticable through the agency of individual or competitive medical practice, it should be clear that many of the present activities of hospitals may be made to contribute materially to this end.

In this connection, let us consider one of the hospital's chief obligations, record keeping. The clinical record of hospitals and dispensaries consists of social, scientific and administrative facts. The principle involved in collecting the social and scientific facts pertaining to the degenerative diseases, facts that will enable us eventually to deal with these conditions more accurately, is not different from the now universally accepted epidemiological study made for communicable diseases. If the degenerative as well as the communicable diseases are ever really to be controlled, this control will not be gained by the providing of curative medical service after the disease has become easily recognizable, but by the collection of accurate and authentic data that will reveal the exact nature and cause of these degenerative disturbances and by the establishment of such a relationship between the individual and his medical adviser as will enable the individual to acquire the information about medical subjects necessary to the proper ordering of his own life, and will, on the other hand, enable the physician to recognize disease producing tendencies, or the indications of disease, at a time when curative or remedial measures may be undertaken with some hope of success.

Control Degenerative Diseases

This movement to control the degenerative diseases will be greatly strengthened by the development in the public mind of a greater appreciation of hospital service for health as well as for sickness. This development should be initiated and carried on vigorously by hospital administrators, their medical and surgical staffs and the medical profession at large.

Were we to consider the hospital alone, there is adequate justification for accurate and complete records. To quote Dr. Haven Emerson, professor of public health administration, Columbia University, New York: "There are the patient, the physician and the hospital to be protected against inadequate service, against the loss of data precious to the patient and society and against claims of malpractice or neglect. Facts upon which improvements in hospital procedure and management can be based, by which policies and the principles of administration can be tested require an analysis of the experiences with disease which the bedside and laboratory service offer. Health, human salvage, relief from pain, from disability, from fever and from anxiety, and postponement of death—these are the hospital's output."

To this end every hospital has the right to demand the greatest possible degree of accuracy of

diagnosis upon admission; a complete, detailed health examination not limited to the system or part showing most obvious damage, and appropriate instruction while in the hospital to enable the patient to avoid a repetition of the trouble. Thus physicians and hospitals may be saved the humiliation of seeing patients return for conditions that should have been corrected at the first visit.

Early and Accurate Diagnosis

Just as the curability and prevention of tuberculosis, syphilis and other communicable diseases depend upon an early and accurate diagnosis, so the presence and extent of a community malady must be early recorded and analyzed if we would apply the appropriate cure and prevention. The hospital can become a source of abundant, trustworthy data on the nature and origin of disease. Hospitals now occupy a strategic position in advancing our knowledge concerning the quantity and quality of sickness and in detecting the results of preventive medicine.

Educational Work Important

From the foregoing it may be inferred that the hospitals have not discharged their full duty to patients simply by providing accredited medical and nursing care. Prevention of sickness and postponement of death must be accomplished by appropriate education of the individual as well as by early detection of disease and application of medical measures. This educational work is especially important in the field of maternity and infancy. Of scarcely less importance is the instruction needed by the diabetic, the heart case, the individual recovering from pneumonia and the mothers of children recovering from nutritional disturbances. In fact, few who are admitted to the hospital are in such perfect condition when discharged that a standing order for instruction appropriate to the individual and the conditions from which he is suffering would be inconsistent with the best hospital practice. One scarcely needs to mention that caution should be used in the methods employed. It is, of course, the attending physician, who is in every instance an unofficial health officer, who should give this instruction. The hospital should never hesitate to remind the busy practicing physician of his duty.

Already many of the hospitals for tuberculosis, communicable diseases and the insane have entered the field of preventive medicine by conducting through their dispensaries as well as in the hospital proper the educational work indicated above. There is now a pressing need for a more

flexible service and a less rigid adherence to precedent and prejudice among so-called general hospitals.

The hospital occupies a strategic position between the profession and the public. It has open to it a great opportunity and a correspondingly great obligation, not only as an institution for the salvage of human wreckage but as a co-ordinator of professional, economic and social activities in their application to the problems of health.

If such is the obligation of hospitals then it is not asking too much to require that they provide for their entire personnel sanitary surroundings, adequate and suitable diet and a properly proportioned daily life from the standpoint of occupation, intellectual development, recreation and rest, in keeping with their high standard of professional performance.

COMMON SENSE WILL SOLVE THIS PROBLEM

The harrassed and overworked hospital superintendent is sometimes led to wonder how it is possible for kitchen machinery to continue its operation in view of the way that it is neglected and maltreated.

When the dishwasher fails to turn out clean dishes, one would think that the operator would look it over to see what was the matter. Perhaps it might cross his alleged mind that it is his duty to scrape the dishes a little better before he puts them in. When the soapy water overflows, it would be natural to imagine that he would realize that he was feeding the trays too close together. But no. He continues to operate the machine, turn out dirty dishes, flood the dishwashing room and perhaps injure a valuable piece of machinery.

A case has just come to our notice in which half-a-dozen plates and a handful of silverware had been allowed to slip down to the bottom of the machine. It speaks well for the manufacturer that the machine was not entirely wrecked, but what does it speak for the intelligence of the operator? The hospital superintendent notes that the bread is torn as though it had been sliced off with a very dull saw. One would think that the operator of the bread-cutting machine would take a look at it to find out why it was mangling the bread. It merely needed the lifting of a cover to see that the blade, through long use, had become very dull, a matter that was rectified by a few moments' work. It is such occurrences as these that put gray hairs prematurely on the hospital superintendent's temples. It seems that it is impossible for man to create an absolutely fool-proof machine and that the only solution to the problem is to employ, as nearly as possible, machine-proof fools.

NEW USE FOR PAPER TOWELS

The use of paper towels has been largely restricted to the wash rooms. Their use can be extended, however, after the manner of one chef in a large New York hospital who keeps a roll of them in the kitchen at all times. They are used in place of rags to wipe up grease and scraps. Paper towels are more expensive, of course, than rags, but they are more sanitary, which justifies their cost.

NOTES ON ADMINISTRATIVE PROCEDURES

MAKING DEPARTMENTAL RECORDS MORE INFORMATIVE

From Dr. Walter E. List, superintendent, Minneapolis General Hospital, Minneapolis, Minn., comes the following statement and examples of his system for keeping departmental records:

"Any hospital, regardless of size, can arrange to have submitted to the superintendent once each month departmental reports that will give a complete statement of the activities and the cost of each.

"If each department head will daily make note of all activities, then translate such notes into a monthly report, both the department and the administration will have an accurate knowledge of just what is being done in each department day

by day; be in intimate touch with the situation at all times, and have provided a working basis for the development of a monthly comparison. If this work is done each day, at the end of each month it is a simple matter to compile a monthly report that will be a complete index, or monthly production sheet, of all departmental activities. These monthly departmental reports made continuously over a period of a year, provide an excellent basis for the development of an annual report, and one that would be of particular value when a year by year comparison is made. These reports should be detailed and specific in statement, so that anyone can read the real facts and make their own evaluations.

"The following forms present the basis of the system in use in the Minneapolis General Hospital. From these any hospital should be able to develop a system to meet its individual requirements."

In addition to the section of the report from the clinical laboratory, shown in the accompanying reproduction, Dr. List requires a complete list of all items, supplies and equipment in this section. This list is divided into the five subhead-

PATHOLOGIST'S MONTHLY REPORT

October, 1925

	1	2	3	4	5	6	28	29	30	31	Total
BLOOD: Haem.	14	19	15	32	15	17	16	13	21	11	516
Eryth.	15	19	15	31	16	17	14	13	24	15	512
Leuco.	16	21	23	37	20	28	33	16	28	23	687
Diff.	16	19	14	30	12	15	31	10	24	13	525
Morph. ....	..	..	1	3	..	..	..	..	..	..	32
Mala. ....	..	..	..	..	..	..	..	1	..	..	1
Coag. Time ....	..	..	..	1	..	2	..	1	..	..	9
Bl. Time ....	..	..	..	..	..	1	..	..	..	..	6
Group ....	..	..	..	2	..	..	1	..	..	..	24
Widal	1	..	..	..	..	..	..	..	1	..	7
Wass.	55	..	..	68	..	..	56	..	..	..	568
Bl. Cult. ....	..	..	1	..	..	..	..	..	..	5	14
Vt. Stain ....	..	..	..	..	..	..	..	..	..	..	..
Frag. Test ....	..	..	..	..	..	..	..	..	..	..	1
URINE: Routine	35	32	36	52	54	34	45	51	45	19	1,129
Cystos. ....	..	..	..	..	..	..	..	..	..	1	2
Cult. ....	..	..	..	..	..	..	..	..	..	..	2
BODY FLUIDS: Spinal	3	2	1	2	3	3	1	1	2	2	37
Thoracic ....	..	..	..	1	..	3	..	..	1	..	11
Abdom. ....	..	2	..	3	3	3	..	..	..	..	13
FECES: Routine	4	4	3	5	3	5	2	1	1	..	65
B. Typhosus ....	..	..	..	..	1	1	..	1	..	..	16
CHEMISTRY: Bl. Sugar	11	..	4	..	8	8	12	8	6	1	104
Bl. Creat.	8	..	4	..	6	6	10	..	3	1	90
Bl. Urea	8	..	4	..	6	6	11	..	6	1	97
Bl. Uric. Acid.	1	..	2	..	3	3	..	..	..	..	23
Bl. Van Slyke ....	..	..	1	..	..	..	..	..	..	..	6
Special	1	..	..	..	1	1	3	1	5	..	21
Urine Albumin	2	3	3	3	2	3	1	2	3	2	73
Sugar	7	7	6	6	6	4	8	8	7	8	145
P. S. P. ....	..	..	..	..	..	..	..	..	2	..	12
Gast. Ana.	1	2	..	..	..	..	..	6	..	..	18
Duc. Cont. ....	..	..	..	..	..	..	..	..	..	..	..
Special ....	..	..	..	..	..	..	..	..	..	1	2
BACTERIOLOGY: Smears	17	..	8	32	6	20	28	3	8	..	362
Culture ....	..	..	..	..	4	..	..	..	..	..	11
Thr. Culture	1	4	1	6	..	7	7	3	..	..	99
Anim. Inoc. ....	..	..	..	..	..	..	..	..	..	..	3
Sputum T. B.	9	3	5	4	5	..	8	10	8	11	136
Sputum Org. ....	..	..	..	..	..	..	..	..	..	..	5
Sputum Pneumo.	3	..	3	5	..	..	6	8	5	1	73
FUNGI .....	..	..	..	..	1	..	..	2	..	..	3
DARK FIELD	1	..	..	..	..	..	..	1	..	..	8
TISSUES	2	..	..	1	3	..	2	..	3	..	41
BASAL META.	2	..	1	..	1	..	..	..	..	..	18
AUTOPSIES	2	2	1	2	..	..	1	..	..	..	18
COLLOIDAL GOLD	3	4	4	1	1	4	2	2	1	4	55
DISPENSARY	51	25	7	27	32	27	43	28	20	21	725
TOTAL	200	260	151	297	262	216	288	191	282	134	6,413

This chart shows the monthly report from the x-ray department of the Minneapolis General Hospital. At the end of the year the monthly reports are compiled into a single statement and this, together with the monthly reports of the other departments of the hospital make up the annual report of the institution. In this way a complete and almost daily index forms the annual report.

CLINICAL LABORATORY

October, 1925

	Sick Leave	L. O. A.	Vacation
PERSONNEL			
Pathologist-director, 1 M.....	\$ 385.00		
Chemist, 1 M.....	150.00		
1 technician, 1 M.....	120.00	1 day	
1 technician, 3 M.....	110.00		
1 technician, 1 M.....	100.00		
1 clerk stenographer, 3M.....	70.00	15 days (resigned 10/16/25)	
1 orderly (part time), B. & R.....	50.00		
1 maid, B. & R.....	40.00		
	\$1,025.00		
Paid workers	8		
Students	10		
New students	3		
Students finished	2		
Total workers	18		
SALARIES			
Authorized	\$1,025.00		
Paid	975.00		
SUPPLIES AND EQUIPMENT—(See itemization)			
Household	14.23		
Stationery	13.00		
Scientific equipment	62.94		
Feed	9.48		
Chemicals	59.90		
	\$ 159.55		
COST OF MAINTENANCE	1,184.55		
DEDUCTIONS			
Income from dispensary	48.40		
Student's fees	50.00		
Sale of animals	2.00		
Refund of salary	1.61		
	\$ 102.01		
NET COST OF MAINTENANCE	1,082.54		
NUMBER OF EXAMINATIONS—(See table)			
Hospital	5,608		
Dispensary	725		
Total	5,413		
		Average per day.....	\$34.16
		Average per day.....	32.50
		Average per day.....	.47
		Average per day.....	.43
		Average per day.....	2.10
		Average per day.....	.31
		Average per day.....	2.00
		Average per day.....	5.31
		Average per day.....	\$ 3.40
		Average per day.....	36.08
		Average per day.....	210
		Average per day.....	27
		Average per day.....	227

ings shown in the reproduction. Under each sub-head is a complete listing of expended materials detailed to include the smallest items. Nothing is overlooked in this itemization, everything from 38,000 cubic centimeters of alcohol down to one letterhead or a box of matches is included.

SCHEDULING VACATIONS

With the approach of the summer months, vacation schedules are in order. A few hospitals start vacation periods with the month of April. The majority, however, arrange vacations so that they will fall in the months of May, June, July and August.

By common acceptance, two weeks has become the universal vacation period, although in the South, particularly the southwestern states where the heat is excessive and of long duration, periods of four weeks are allowed to department heads and graduate nurses. Where four weeks are allowed, however, the additional two weeks are usually taken at the expense of the employee, only the first two weeks of the period carrying the regular salary. Some hospitals, however, find it advantageous to cut the periods for certain classes of personnel, such as domestic help, to whom only one week is given.

During the last week in April or the first week in May, the vacation schedule is either posted on

the bulletin board or passed to the various department heads, who arrange the allotment of periods so as to interfere as little as possible with the established routine.

In some hospitals it is standard practice to grant the privilege of selecting the vacation periods according to priority of service, that is, the employee longest in continuous service is given the first choice of vacation periods, the employee having the second longest continuous service record, taking second choice, and so on.

As an example of good vacation ruling, we quote from Dr. F. M. Hollister, superintendent, Brockton Hospital, Brockton, Mass.:

"All employees and graduate nurses, when connected with the hospital eleven and one-half months or longer, are eligible for two weeks' vacation, with pay. In the case of graduate nurses, two additional weeks may be taken, but at their own expense.

"Vacations for graduate nurses must be scheduled for periods between June 1 and September 10. Senior pupils, having completed classroom training, will schedule their vacations for the months of April, May and September. Intermediates and juniors, for June, July and August.

"To avoid misunderstanding with regard to the dates of return to duty, each pupil will be supplied with the following slip, filled in and signed by the superintendent of nurses:

"Miss _____ vacation ends _____. She shall be in the nurses' residence by nine that night and shall report for duty and leave this slip at the training school office the following morning.

Superintendent of Nurses."

"Terminal vacations will be allowed employees and graduates.

"Pupils will not be allowed to go without vacation for the purpose of shortening the course.

"All vacations must be posted one month in advance. No changes allowed."

This ruling is one that many hospitals might well adopt in principle.

MAKING RECORD KEEPING WORTH WHILE

"IT DISCOURAGES a physician to be forced to duplicate or to lose his work because of poor record keeping or an inadequate system," said a physician at a recent joint committee meeting of superintendents and physicians working in clinics. A physician cannot do his best work unless records are fully kept and readily available. The application of business principles to out-patient service must include good records and good record keeping.

The physician who is apparently indifferent to record keeping will become interested and co-operative if the system is well devised and adequate clerical help is given him. Good record keeping in an out-patient department depends, among other factors, upon the number of patients and whether or not there are social workers who can take certain parts of the history, and clerical workers who can help the physician. Some clinics do not feel that they can afford such aid.

But this brings up the question of values. How is cost measured? Is it measured purely in terms of the cost of the increased service made possible by a complete record and physicians released from non-medical duties?

How Long Shall Records Be Kept?

From the standpoint of an ideal system, aid to the physician is necessary so that he can devote himself unreservedly to medical duties. Patient, institution, and physician will benefit by good record system strengthened by good record keeping, for the best type of medical man is attracted to the institution maintaining such a system.

One question that vexes many out-patient executives is how long records should be kept. The records stored away for possible future reference require storage space and a certain amount of care in making them readily available. How valuable are they? Storage space is important but secondary where saving of medical history is concerned.

The patient's record is valuable as history, especially as examinations become more popular. It is also valuable from a legal aspect. It gives a picture of the life span of the individual. Sometimes from the viewpoint of the study of heredity it is worth keeping.

One way to save the record, or at least the important parts of it, and at the same time to conserve storage space is to abstract it. The advantage is that the record is reduced to a minimum both as to size and contents. Much that is important in the current history of a case may

be worthless for future references. On the other hand, abstracting is costly in that it requires close medical supervision and time.

It is foolish to save records in a mediocre institution where the histories have been indifferently or poorly kept. The better the record and system the more important its preservation becomes. In a decentralized record system where there might be duplication in medical findings and other information about the patient, the question of values is more pronounced. Possibly in this situation abstracting would be an advantage. For both current and historical purposes the unit history presents the best type and in an ideal record system histories should be kept in perpetuity.

Physician Should Take History

Is it advisable or practical for the physician to delegate to a nurse, a social worker or a clerk the responsibility of taking the medical history? One hospital superintendent said, "Two and a half years' experience with skilled aids in the clinic has convinced me that medical histories must be taken by the physician. Otherwise, there is always danger of a careless checking up on his part."

There are perhaps certain clinical items and certain types of histories that could be taken by a clerical assistant; on the whole, however, the taking of the medical history by the physician is an absolute requisite in most medical cases. In delegating this task to an aid the physician interposes an element between himself and his patient that makes it harder to get at the medical difficulty. As he is taking the history he is already summarizing in his own mind the outstanding points of the patient's condition. Many diagnoses would be incorrect if the physician did not take the medical history himself.

This is the keenest way of running disease to its lair. Then, too, closer confidence between patient and physician is established through the questions and answers of history taking, side-lights are brought out that are of significance, and the physician's interest in the case is enhanced. The patient's narrative report—not his routine answers to routine questions—and the physician's written narrative, are the most important elements in the medical history of a patient.

Should the doctor do any actual writing? This depends upon the resources of the clinic and the physician's desires. But he should sign his name to all records made in his clinic. This will call his attention to their contents and will place the responsibility upon him. Initialing is not sufficient, since with the change of physicians on a service initials are hard to identify.



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MORE WORLDS TO CONQUER

THAT there are still many medical worlds to conquer is convincingly set forth in a masterly article by Dr. Alexis Carrel on "The Future Progress of Medicine," in this issue of THE MODERN HOSPITAL.

It is not surprising that the giant forward strides that medicine—particularly in its preventive phase—has taken in the last three or four decades should be not properly evaluated by those fortunate ones who benefit immediately by these advances.

It is proper that this generation should pause and thankfully survey these medical triumphs, the results of which are everywhere evident. But, when we consider that the very captains of the army of death—cancer, heart disease, and tuberculosis—have as yet been hardly scotched, it is evident that these scientific victories have but too frequently been over lesser enemies.

Doctor Carrel sounds a new and profound note when he suggests that from the clinician, the physiologist and the chemist must come a new knowledge, which will explain and correct those vagaries of human character that are expressed in lack of sympathy, in cruelty, or in unmoral or anti-social conduct.

The future of medicine must be affected in no small degree by the future of the world's hospitals. For whether the investigator's field of endeavor be clinical, or pertain to laboratory or public health medicine; whether he strives to cure or prevent disease, the starting point—the stimulus—will usually be at the patient's bed in the hospital ward. Indeed, even though the investigator separate himself from the human appeal which daily surrounds the hospital laboratory worker, and by the pure light of science seeks to learn the ultimate concerning human life and death, still, in the last analysis, such truths must bear fruit in the hospital ward.

It may be that the hospital has too long been content to fill the role of a repair shop for broken-down human beings. Is it not likely that our institutional eyes have been so focused on the immediate work of cure that our vision has been clouded to the broader possibilities of prevention? The future hospital will certainly give departmental recognition to the work of saving men and women from being sick; to teaching the science of prophylaxis in disease, and this department will be closely linked with the hospital's research laboratory, from which will come continually a fresh scientific stimulus, to renew and revive the worker's zeal.

It has been suggested that there may appear in

the hospital field institutions that are wholly preventive in character, and that would function solely in this way, even as does the research hospital of today, with its comparatively few beds, and much laboratory space. But neither the clearest prophetic vision, nor the most ardent public health optimist, can discern any near-by indication that human bodies will not wear out. The degenerative diseases, particularly of the cardiorenal system, as well as illnesses of the mind, will, without doubt, long continue to furnish their legions of patients, who will demand extended periods of hospitalization.

But the type of the future hospital will certainly be altered. Fewer beds for the contagious diseases, for the infectious fevers, particularly typhoid fever, and more for the brief periodic study which routine health examinations demand, as well as for the care of the much neglected chronic patient, will surely be required.

But curative effort should not, must not falter, and it is not unreasonable to expect great advances in treatment methods in the future hospital. Heliotherapy is but in its infancy, and deep x-ray therapy, with instruments of precision for the accurate measurements of depth of tissue penetration, and of actual dosage, promise much along lines of the treatment of cancer and allied conditions. Our hospitals must be alert, not to follow the trend of the medical times, but to lead in any constructive advance that will lower morbidity and prolong human life.

UNRECOGNIZED HEALTH FORCES

THE first American Health Congress will be held in Atlantic City, N. J., May 17-22.

There will gather for the first time representatives of fourteen national organizations interested directly or indirectly in health work and hundreds of health leaders.

A glance at the rostrum of the National Health Congress impresses us with the widening of the horizon of health interests. A few years ago there were few, if any, national organizations for the prevention or control of certain types of diseases or affliction, and those that did exist were not thought of in terms of a positive force in promoting the general health.

We are slow to recognize prevention as a positive force in health until the work of certain organizations or institutions concerned with disease prevention is strikingly brought to public attention. A few years ago the demand for preventive health examinations of the apparently well would have been regarded as a symptom of hypochondriasis. But today the forward looking members of the medical and allied professions are promoting

the movement for periodic examinations of apparently well people as a preventive measure against disease, and the hospitals of the country stand ready to do their part by extending their facilities for this work.

As yet the hospital as an agency of prevention is recognized by few people, but we are not far from the time when it will no longer be considered as the last resort of the dying and hopeless, but a center for the protection of community health.

BETTER PROVISION NEEDED FOR THE MENTALLY ILL

SINCE 1917 administrative and legislative neglect of state hospitals for nervous and mental diseases has been marked in nearly every state in the union. Failure to provide new housing, to accommodate admissions that have increased steadily during these eight years, has produced crowding that is appalling. The public is awakening to the true situation. Legislatures and governors are facing the problem, but are unwilling to attack it courageously because a proper solution means the expenditure of millions of dollars wanted for other purposes.

Various methods for relief have been suggested. The most popular seems to be bond issues, the proceeds from which may be used to erect new wards at existing hospitals and to build new hospitals. By this plan current income of the state would not be diverted at once from the channels where politicians want to spend it.

The Illinois Mental Hygiene Society, for example, petitioned the last general assembly of that state to submit to the people for approval a bond issue of fifteen million dollars with which to enlarge old and erect new institutions for nervous and mental diseases. As this money, if voted by the people, could not be utilized before the latter part of 1927, the society submitted a building program for the intervening time, to be carried out by appropriations of current taxes amounting to several million dollars. The legislature ignored the society's plans but did appropriate a considerable sum for new wards and for a site for a new state hospital.

New York State, following the fire at Manhattan State Hospital, approved a substantial bond issue for rehabilitation of all its eleemosynary institutions, and they will participate in the one hundred million dollar bond issue, approved by the people of the state in November, 1925, for a comprehensive public building program covering many years.

New Jersey voted against a bond issue for its eleemosynary institutions.

All bond issues for this purpose are certain to arouse hostility. The demand is becoming insistent that state and local governments curtail expenditures.

The needs of these institutions cannot be neglected much longer. While they have been suffering, other state projects have been faring well. There should be voted to these institutions out of current revenue, large sums for new buildings, while other state enterprises mark time.

TALKING IT OVER

BLUE Monday, and the well-oiled hospital machinery of Saturday seems to be creaking in every joint! The superintendent's office is figuratively crowded with patients' relatives, who desire to lodge major or minor complaints about real or fancied lack of service to their fathers, mothers, wives, husbands, sisters or brothers. The dietitian has lost her precious chef; the directress of nurses has a serious breach of discipline to present; the engineer reports a breakdown in the refrigerating system; and, as the proverbial straw, the housekeeper and the storekeeper have had a vitriolic personal clash.

"If you can keep your head," Mr. or Miss Superintendent, among all this, Mr. Kipling would certainly decide that you are a superman or woman. If you can't, and if your nerves jangle at the thought of another intruding grievance or mistake, the correct diagnosis and treatment can easily be outlined: Fatigue—mental and physical. Mayhap, the dietitian should be sent to a *matinée* or the engineer to a ball game; or, just as likely, YOU should go fishing or motoring for twenty-four or forty-eight hours, and see how finely things seem to have adjusted themselves on your return.

* * *

SOME people have brains with water-tight compartments. These are the bigots, the prejudiced and the small. They will admit to their consciousness no thought that does not exactly coincide with their own narrow formula of life.

We of the hospital field come in contact with all sorts and conditions of people. If we are narrow-minded, if we have religious, racial, political, or behavior prejudices, we greatly handicap our usefulness. It is our duty to maintain an open mind toward the whole world if it is to be made a healthier and better place in which to dwell. Dealing with the sick in mind and body as we do, we can never do our full duty to them by the exercise of intolerance. The great foe of quackery is knowledge and service, and the more we know and the better we do our life work, the greater should be our understanding of those whose beliefs and practices are different from our own. An open mind tempered by a conservative skepticism will protect alike against gullibility and narrow intolerance.

* * *

EVERYBODY makes mistakes—that's why we use napkins. A wise man makes one mistake, a fool makes it the second time. Mistakes should not be taken to heart. We should learn from them but never brood over them. There is no such thing as an irretrievable error unless by worrying one makes it so, or by stupidity, makes the mistake again. To rowl oneself over a mistake is the acme of egotism. It should be remembered only as a warning not to repeat it. In any event, we should

not try to hide it, to sneak out of it or to transfer the blame to someone else. That is childish and an evidence of immaturity. One should admit a mistake frankly and take the consequences. As a result character is strengthened but if we evade responsibility, we weaken ourselves.

* * *

WHERE is the social-service department? Is it aiding in getting people well? Is it obliterating the distance between home and hospital by daily taking the hospital, with its teachings, into the home, and transplanting and translating the place where sickness began to the place where health is being restored? Is it aiding the doctor to more speedily return earning power, and to re-establish the family circle? Or, is it collecting bills, and carrying packages? The latter functions are of the greatest importance, but can we not get them done by less trained and less expensive persons than we should find in the department of social service?

* * *

A SUPERINTENDENT of a psychopathic hospital was solemnly making his rounds. He stopped by the bed of a patient whose mental and physical unrest was such that restraint was necessary. "Who are you?" said the patient. The superintendent, not a little startled by the sudden and forceful interrogation, replied, "Why, my man, I am Mr. Blank, the superintendent of this great institution." "That is all right, Mr. Blank, but you better get out of here quick. I am Julius Caesar, but that doesn't get me out of here."

* * *

DEAN INGE, in commenting on Omar Khayam's "There was a door to which I found no key," remarked that perhaps the door wasn't locked. To many of us it may appear that the door of opportunity is closed and we spend much effort in looking for the key to unlock it when all that we have to do is step boldly up and turn the knob. It is doubtful if there is any lock at all on that portal and all that is needed is enough vision to see the door and sufficient energy to swing it open. There is always a way to make our labor more productive, to increase the output per working day, to make ourselves more useful and to extend that usefulness to broader fields. The man who says that there is no opportunity for advancement in his present position is blind to the door that will open invitingly at the lightest touch.

* * *

IF YOUR hospital suffers from an annual plague of mosquitoes and flies, it may be that this results from failure to anticipate this annual visitation and to take adequate preventive measures. The time to begin this work is in the early spring before the mosquitoes and flies have had opportunity to breed. A survey should, therefore, be made of the hospital buildings and grounds to see that there are no places in which these insects may multiply. Look over little pools of water, make a survey of the roof gutters, the drainage system of the grounds, study the neighborhood for manure piles, defective garbage cans and all places that will breed or attract flies. Go over the screens and the screen doors carefully and see that they fit properly and have no holes through which these insects might gain entrance. Sometimes it is necessary to install electric fans which will blow flies away from the door. It is not the purpose of this paragraph to tell just what shall be done and how to do it, but to stimulate interest in the matter of fly and mosquito prevention. The presence of these insects in a hospital

is a reproach to the management. It is a bad example to the community and, worst of all, it is a positive menace to the health of patients and personnel. If the hospital will take an active interest in keeping itself free of these noxious vermin, it will stimulate community public health work.

* * *

DID you ever stop to think what an important part imagination may play in hospital organization? It is a quality of mind that has been more potent and productive than all others that adorn civilization. Without it there would be no inventions and no literature, faith in the future would be dead and progress would cease.

Imagination is the parent of the phonograph, the telephone, and the airplane, and but for it, all the modern conveniences of hospitals would not be. The field of hospital administration is not a humdrum slough of routine—at least it should not be—and there is much in it to stimulate the imagination to better accomplishment and higher ideals. Imagination, directed into proper channels, will improve the atmosphere of the hospital field, will build more and better hospitals, and will give to the public more and better service.

We need more men and women with bigger, broader and more active imaginations, people who are able to dream dreams and who have the courage and tenacity of purpose to make their imaginings reality. New ideas are nothing in the world but new imaginings. They should be encouraged, and every employee who has a new thought for the improvement of the hospital and its work should be encouraged and rewarded.

* * *

THERE is a golden commodity that the gods have bestowed generously on some hospital superintendents. "What stuff 'tis made of, and whereof it is born," we know not. Frequently we do not sufficiently note and praise its presence, but usually we condemn its absence. It is the lubricant that causes the hospital machinery to turn noiselessly and efficiently. It is the stimulus that causes executives to praise, when to blame would ruin a good department head; and to censure, when to compliment would make another giddy. If the gift is ours, we delay or withhold a reprimand, because the offense was not deliberate, or because we know anger must abate before clear vision and normal judgment will return. It comprises an understanding of human frailties; a knowledge of the principles of wise leadership. It is the mark of a good executive and the essence of all sane discipline—it is TACT.

* * *

"A PENNY saved is a penny gained." Old sayings are often true sayings. To save a penny is often to earn two pennies. The hospital salvage department frequently supplies not a few dollars for purposes too trivial or unusual to include in the regular budget. To bale and sell waste paper; to recane chairs; to salvage and sell discarded rubber goods; to dispose of x-ray plates; to mend the thousand and one articles—to do which no one seems to have time—appear but small and troublesome duties, but it is surprising how speedily pence become dollars when this department is functioning properly.

* * *

DO YOU have one member of your staff who never is satisfied with anything? If he is a surgeon, if the catgut is all right, are the scissors dull, or the sponges too small? Does this man try your soul, so that your

sleep is made vocal with speeches which you plan, and caustic comments which you formulate, to overwhelm the objector? Such a character is indigenous to almost every hospital and is often a blessing in disguise.

The worst disease to which the administrator is heir is "hospitalitis"—contentment with present routine and accomplishments. To become "rutted" is fatal, but the complainer is the cocklebur, which will surely, if not painlessly, save your institutional soul. Take him to dinner; get his outlook on hospital work; convince him, make him convince you, of a mutual and paramount desire to serve the patient, and experience the joy of acquiring a new and enduring confidence in the good intentions of most men.

* * *

ONE of our Eastern correspondents writes us as follows: "In one of our great cities there is a hospital which during the hot weather last summer displayed on the glass of its front doors this unusual sign:

"DANCING ON THE ROOF MONDAY AND SATURDAY EVENINGS."

"Dancing on the roof of a hospital," I repeated to myself—what an unorthodox proceeding! And as the day with its tiresome routine and oppressive heat drew to its close, this cryptic phrase occurred and recurred in the phonographic record, which we call "memory."

"Dancing on the roof!" And yet, thought I, should not the hospital be more than a place of pain and suffering? Should it not be a place where common people dare to come when they are not ill, and to which the poor man or woman may look for helpful advice; for a real human understanding of troubles that are not physical? May not an inadequate income, or the waywardness of a growing girl be so conducive to family unrest or even actual illness, that the hospital may perform a real preventive function in aiding to solve such problems. It may not be (indeed, it rarely will be) dancing on the roof that encourages the use of the hospital as a real community center; but in whatever way seems locally best, let us reach out with the arm of service and bring to our front doors the community needs, whatever they may be."

* * *

AHILL has a crest, a brow, a face, a foot; volcanoes vomit lava and belch smoke and ashes; we speak of a tongue of land, the horns of a dilemma, the clutch of circumstance, the hand of fate, the long arm of destiny, the body of the law; chairs have arms, legs and feet, clocks faces and hands, beds have heads and feet, bottles mouths and necks; clocks run, duty calls, secrets leak out, accounts balance, exchange falls, prices soar.

What does this apparently meaningless collection of words mean to you, gentle reader? Merely, that the speech of man which is the reflection of his thought is a series of word pictures—symbols. It is often said that man is still in the picture-reading stage; how much better it would be to say that he has always and always will be in the picture-thinking stage. Man is an animal that symbolizes. He thinks, dreams, worships and follows symbols. What symbol does the thought of a hospital raise in your mind? The rainbow of hope, the healing sun, the protecting bandage, the cool bed, the aiding crutch, the soothing hand? This is something worth thinking about. Put your thoughts on paper and send them to this department. The hospital field needs insignia, a symbol, a badge, some simple device that shall crystallize the spirit of its service.

NEWS OF THE MONTH

OHIO ASSOCIATION TO CONSIDER LICENSING PROBLEM

A proposal for the licensing of all general hospitals as well as maternity hospitals and inspection by the bureau of hospitals, State Department of Health, will be one of the important problems for discussion before the annual convention of the Ohio Hospital Association to be held in Columbus April 6, 7 and 8.

A joint committee of the Ohio Hospital Association and the State Department of Health has been at work on this project and is expected to make a report with recommendations at the annual convention. A. E. Hardgrove, Akron, president-elect of the association is chairman of this committee. Other members of the committee are: B. W. Stewart, Youngstown Hospital, Youngstown; Mary Jamieson, Grant Hospital, Columbus; Rev. A. G. Lohman, Deaconess Hospital, Cincinnati; C. A. Brimmer, Mansfield General Hospital, Mansfield; Dr. H. E. Kleinschmidt and Dr. J. A. Frank, the latter two representing the State Department of Health.

The program for the twelfth annual convention of the Ohio Hospital Association includes a business session with reports of officers and committees on the afternoon of April 6 with a dinner meeting in the evening. Speakers have not yet been selected.

On Wednesday morning April 7, "Hospital Housekeeping" will be the general subject with discussion of interior decorating, food service, fire hazards, power and fuel, landscaping and kitchen and laundry problems. Specialists in these various problems will lead the discussions.

Wednesday afternoon's session will be given over to a round-table discussion of vital problems including the question of contracts with municipalities for the care of patients, contracts with the Industrial Commission, co-operation with the State Department of Health and the important question of licensure.

The convention will conclude with a round-table discussion Thursday morning on relationship of hospitals to social agencies, out-patient departments and clinics and costs, rates, fees and collections.

The convention will be held at the new Neil House, Columbus, where an exhibit will also be staged. Dr. C. H. Pelton, Elyria, will preside. He is the retiring president and will be succeeded by A. E. Hardgrove.

FIRST AMERICAN HEALTH CONGRESS SCHEDULED FOR MAY 17-22

The first American Health Congress, composed of representatives of the various health and allied national organizations will be held in Atlantic City, N. J., May 17-22. Collateral with this meeting in Atlantic City will be held those of the three national nursing organizations, the American Nurses' Association, the National Organization for Public Health Nursing and the National League of Nursing Education; the annual meeting of the American Child Health Association and the Conference of State and Provincial Health Authorities of North America.

Many health authorities and workers of national and international reputation will participate actively in the conference. Scheduled to appear on the program are Professor C.-E. A. Winslow, president, American Public Health Association; Dr. Ray Lyman Wilbur, president, Stanford University; Dr. George E. Vincent, president, Rockefeller Foundation, New York. Sir Arthur Newholme, who has been actively promoting public health work in England and is well acquainted with public health work in this country, will address the opening session of the congress.

PENNSYLVANIA ASSOCIATION WILL MEET APRIL 13-15

Ways and means of securing legislation favorable to the hospital field will be the chief topic of interest and discussion at the annual convention of the Hospital Association of Pennsylvania which will be held at the Hotel Schenley, Pittsburgh, April 13, 14 and 15.

The meeting will be devoted to morning and afternoon sessions, a banquet being scheduled for the evening of the closing day of the convention. Hospitals of the city will be open for inspection by the attending delegates



Dr. G. Walter Zulauf, president of the Hospital Association of Pennsylvania.

and an exhibition of equipment and supplies will be prepared by the manufacturers.

Dr. G. Walter Zulauf, superintendent of the Allegheny General Hospital, Pittsburgh, and president of the association, will preside at the meetings of the convention. John M. Smith, director, Hahnemann Medical College Hospital, Philadelphia, is executive secretary of the association.

NURSING ORGANIZATIONS PLAN UNIQUE MEETING WITH HEALTH CONGRESS

Plans are complete for the twenty-fifth convention of the American Nurses' Association to be held at Atlantic City, N. J., May 17-22. One of the outstanding features of the meeting will be the participation of the association in the American Health Congress, to be held simultaneously.

A feature of unusual interest will be the private duty section of the association to be held on May 18. The section will be in charge of Helen F. Greaney, chairman, and Adda Eldredge, president of the association, who will deliver an address to the private duty nurses. Other speakers who will present various phases of the subject at this meeting are Janet Geister, Committee on Dispensary Development, New York, and Anna Gladwin, Akron, Ohio.

On Tuesday evening will take place the joint session of the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing.

On Wednesday, May 9, the high light of the day will be the joint session of the three nursing organizations.

Legislative measures pertaining to schools of nursing and the administration of laws governing the registration of nurses will be under discussion at the meeting Wednesday morning at which Louise Dietrich will preside.

On Thursday, May 20, another joint meeting will be held with the American Health Congress and a conference on official registries for nurses.

DR. SCHROEDER, WESLEY MEMORIAL HOSPITAL, DIES

Dr. William Edward Schroeder, chief of staff, Wesley Memorial Hospital, Chicago, for the last ten years, died March 5 in St. Petersburg, Fla. In addition to his connection with the Wesley Memorial Hospital, he was surgeon at the German Deaconess Hospital, Chicago.

According to E. S. Gilmore, superintendent, Wesley Memorial Hospital, Dr. Schroeder's library, valued at \$25,000, has been given to the hospital.

VETERANS' BUREAU HOSPITAL OPENED AT GREAT LAKES

Although workmen are still employed in the four units of the U. S. Veterans' Bureau Hospital No. 105, located at the Great Lakes Naval Training Station, Great Lakes, Ill., which were opened March 1, twenty urgent mental cases have already been transferred to the institution. This hospital, the newest veterans' hospital, is intended to care for all the mental cases in the eighth district.

When the entire project is completed the units will lie roughly in a circle, with a graceful drinking fountain in the center. All the units, when erected, will provide accommodations for 1,000 veterans. Dr. O. C. Willhite, medical officer in charge, has a staff of six medical men, fifteen nurses and fifty attendants, at the present time.

CATHOLIC HOSPITAL EXECUTIVES AND NURSES TO HOLD JOINT MEETING

The International Catholic Guild of Nurses will hold its third annual meeting this year in conjunction with the eleventh annual convention of the Catholic Hospital Association. Both of these conventions will take place in Chicago, a few days before the great Eucharistic Congress which is to meet there. The nurses' convention and the convention of the Catholic Hospital Association will be held at Loyola University, Rogers Park, Chicago, from June 14 to 17. The Eucharistic Congress will take place in Chicago from June 20 to 24.



One of the main buildings of Loyola University, Chicago, site of Catholic Hospital Association convention.

The keynote of the Catholic Hospital Association Convention will be "Religion and Science" and the same theme will run through the program of the International Catholic Guild of Nurses. Special stress will be laid, however, on the educational programs of the guild, and nurses from all parts of the world will be invited to attend the conference which will have a truly international atmosphere.

The local branch of the International Catholic Guild of Nurses in Chicago has been organized at the suggestion of Rev. Edward F. Garesche, S.J., general spiritual director, in anticipation of the proceedings of the congress at a meeting at Loyola University, at which 300 nurses from all the hospitals of Chicago and vicinity attended. May Kennedy, directress of the Illinois School of Psychiatric Nursing, was chosen president of the Chicago local branch of the International Guild of Nurses, and Mary C. Looby, St. Bernard's Hospital, Chicago, was chosen secretary.

The Chicago branch of the guild has been requested by the Eucharistic Congress committee on health and sanitation to act for the committee in organizing the alumnae of the Catholic schools of nursing to take care of the pilgrims during the Eucharistic Congress.

Those members of the International Catholic Guild of Nurses who wish to make reservations to attend the conference and the congress should write as soon as possible to the Secretary of the International Catholic Guild of Nurses, 124 Thirteenth Street, Milwaukee, Wis.

PROTESTANTS TO CONVENE IN ATLANTIC CITY

The sixth annual convention of the American Protestant Hospital Association will be held at Atlantic City, September 25, 26, 27, 1926, according to an announcement recently made by Dr. Frank C. English, executive secretary of the association. The session will begin on Saturday, September 25, and will close at noon Monday, September 27, in order that delegates may attend the opening meeting of the American Hospital Association which convenes Monday afternoon, September 27.

PALM BEACH SOCIAL EVENT BENEFITS HOSPITAL

Front tables which seat four persons at the Montmartre Rex club, Palm Beach, Fla., usually cost \$50 but the price was raised to \$1,000 a table on the evening of March 8, when the entire proceeds were donated to the hospital fund of the Good Samaritan Hospital, West Palm Beach. All tables were quickly reserved.

Among those who occupied tables were: Rodman Wana-maker II, New York; Tony Pulitzer, Chicago; Mr. and Mrs. E. T. Stotesbury, Philadelphia; Mr. and Mrs. J. Leonard Deploe, New York; Mr. and Mrs. J. P. Donohue, New York; Mr. and Mrs. Guernsey Munn, Washington; Mr. and Mrs. Earle P. Charlton, Fall River, Mass.; Mr. and Mrs. Louis G. Kauffman, New York; Mrs. William Randolph Hearst, New York; Mr. and Mrs. E. F. Hutton, New York; Joseph E. Widener, Elkins Park, Pa.; Mrs. Henry R. Rea, Pittsburgh; Mr. and Mrs. A. J. Drexel-Biddle, Jr., New York; Atwater Kent, Philadelphia; Anthony R. Kuser, Bernardsville, Pa.; Otto Kahn, New York; and Mr. and Mrs. John C. King, Palm Beach.

NEW YORK PLANS NEW HOSPITAL IN BRONX

An immediate appropriation of \$1,000,000 and an ultimate amount of \$2,000,000 to acquire a site and erect an up-to-date hospital building was recommended by President McKee of the Board of Aldermen, New York, to the Board of Estimate recently. The new hospital, which is proposed for the southern end of the Bronx, will replace the Lincoln Hospital and Home, which was acquired by the city after months of negotiation. At the time of its acquisition it was estimated that more than \$750,000 would be required to repair the hospital for use.

LOUISIANA ORGANIZES STATE ASSOCIATION

Reorganization of the Louisiana Association of Directors of Schools of Nursing, formed a year ago, into the Louisiana Hospital Association was one of the important events of the first annual meeting of the association held at the Charity Hospital, New Orleans, February 17, 1926. A committee on reorganization consisting of five members was appointed with Dr. John D. Spelman, superintendent, Touro Infirmary, New Orleans, chairman. The committee is to draft a constitution and by-laws and report at the next meeting. The officers elected are: President, Dr. W. W. Leake, superintendent, Charity Hospital, New Orleans; vice president, Nena T. Self, R.N., North Louisiana Sanitarium, Shreveport; secretary-treasurer, Sister Kostka, R.N., Charity Hospital, New Orleans.

Representatives of seventeen hospitals from different

parts of the state as well as the Louisiana Nurses' Board of Examiners attended the meeting. The morning session included a discussion of hospital and school problems with an interesting round table conference conducted by Julie C. Tebo, secretary-treasurer, Louisiana Nurses' Board of Examiners. At the afternoon session the subject of reorganization was considered and it was decided that many of the school problems would be transferred to the Louisiana League of Nursing Education.

PLAN DISTINCTIVE COUNTY HOSPITAL AT COLONIE, N. Y.

Tentative plans have been made by the Commissioner of Charities of Albany County, N. Y., for the construction of a county institution at Colonie which will be a distinct departure from the construction and operation of similar institutions.

It is planned to combine a county hospital with the home for the aged. According to present arrangements, a 787 acre tract of land has been secured at Colonie where a 250-bed institution to be known as the Ann Lee Home, in memory of Ann Lee, founder of the Shakers in America, will be erected. The hospital will not conflict with local acute hospitals but will treat chronic cases, cancer, advanced tuberculosis and some minor medical cases. The essential idea of the institution is to provide a place for the treatment of chronic cases without subjecting the patients to the stigma of pauperism. The hospital will be conducted on the same line as any modern hospital; pay-patients and charity cases.

MASSACHUSETTS GENERAL HOSPITAL PLANS APPEAL FOR \$3,250,000

The board of trustees of the Massachusetts General Hospital, Boston, has recently announced a campaign, the first in its history, for a fund of \$3,250,000 for the erection of new buildings, renovation of the present structures and endowment of research. For more than a century the hospital has been maintained by gifts from public-spirited citizens, since it is neither a state nor city institution.

Chief among the planned projects is the erection of a new branch of the hospital for people of moderate means. This building, which has been made possible through a bequest of \$1,000,000 by Mrs. Mary Rich Richardson, will accommodate, at the outset, 150 patients, together with the nurses needed for their care. Eventually the building will take care of 270 patients.

Other principal items of interest in the planned program of development are additions to and the fireproofing of the Bulfinch Building; increased facilities for the outpatient department; erection of a new ward building, accommodating 150 patients, a new boiler house; and an endowment for the further progress of medicine through research.

ANNOUNCE PLAN FOR HOSPITAL AND UNIVERSITY MERGER

Consolidation of the Presbyterian Hospital of Pittsburgh with the medical school of the University of Pittsburgh, involving the erection of a \$4,000,000 hospital on property adjoining the new Children's Hospital on Fifth Avenue, was announced at a recent luncheon held at the University Club, Pittsburgh, and attended by more than 150 Presbyterian leaders of the Western Pennsylvania district.

The new hospital will have the same relationship with the university as the Presbyterian Hospital of New York bears to Columbia University, with the university directors nominating the hospital staff. The property for the new structure is given the hospital by the university, the site being known as the Kirk Porter property. The hospital will retain its present affiliations, and the consolidation involves few changes in its established plans. The proposed building will provide accommodations for more than 600 patients.

SOCIAL WORKERS ANNOUNCE TENTATIVE PROGRAM FOR MEETING

Tentative plans have been made for the annual meeting of the American Association of Hospital Social Workers to be held in Cleveland, May 24-June 2, 1926. As arranged, the program will be given over to a number of meetings of the section on psychiatric social work and general meetings devoted to round-table discussions.

An analysis of function reports will be given at the general session, May 26, by Mrs. Charles W. Webb, Cleveland. A training report will be presented by Katherine McMahon, Simmons College of Social Work, Boston. A medical social case discussion will also be given at one of the meetings by Dr. Davis, Mount Sinai Hospital, Cleveland.

CHARITY HOSPITAL, CLEVELAND, PLANS IMPROVEMENTS

With the growing tendency of Cleveland hospitals to forsake the downtown district and move to outlying sections, an increased burden is being placed on St. Vincent's Charity Hospital, in the business section of the city at East Twenty-second and Central Streets.

The Charity Hospital administration, aware of the greater need of dispensary and hospital service because of the removal of the other hospitals, has taken steps to alleviate the burden, and announces a campaign for \$1,500,000 with which the present structure will be remodeled and fitted with modern equipment, thus being placed in a better position to meet the needs of its community.

The fact that the Charity Hospital will soon be the only hospital in the downtown district and its present inadequate facilities for dispensary work have prompted the preliminary efforts of the campaign.

SEVENTEEN COMPLETE ADMINISTRATION COURSE AT NEW YORK UNIVERSITY

The course in hospital administration given by Edgar C. Hayhow at the school of commerce of New York University has successfully completed the first term with seventeen students. Most of those who completed the course are superintendents, or subordinate administrators of hospitals in and around New York. The course is now being repeated for the second semester with a registration of eighteen students.

The members of the first class were so pleased with the results that they organized and selected a committee to inform the hospital public of the benefits of the course in hospital administration.

Next year it is planned, and it is already fairly certain, that the course will be extended over two terms or a complete school year. Parallel with the regular course will be a seminar for the consideration of advanced problems in

hospital administration. This seminar will be conducted by one of the most distinguished hospital superintendents, and from time to time he will call to his assistance various specialists to lead the discussion of special problems. As soon as the program for next year's course and the seminar is completed, the committee plans to make a detailed announcement.

It is hoped that the beginning made by Mr. Hayhow will ultimately develop into a four-year professional course leading to a degree in hospital administration. This is an attempt to develop a course along the lines of the work being carried on by Edward A. Fitzpatrick at Marquette University, Milwaukee, Wis.

New York with its many hospitals offers an excellent field for the laboratory method of education, and the school of commerce at New York University is particularly fitted for such a method on account of its diversified hours. The school is conducted on a day and evening schedule so that in addition to hospital administration, one may take courses in public health, accounting, finance, engineering, etc., and so arrange the hours as not to interfere with his daily occupation.

KOSSEFF APPOINTED SUPERINTENDENT AT BETH MOSES HOSPITAL, BROOKLYN

Dr. Abraham Kosseff has been appointed superintendent of the Beth Moses Hospital, Brooklyn, N. Y., succeeding Dr. J. J. Golub, who resigned to accept a position as assistant director of Mount Sinai Hospital, New York. Dr. Kosseff is a graduate of the Long Island College Hospital Medical School, Brooklyn, N. Y., and more recently has been connected with Sing Sing Prison, Ossining, N. Y., as chief physician.

DR. SOMERS DIES IN CALIFORNIA

Dr. George B. Somers, superintendent of Lane and Stanford University Hospitals, San Francisco, died suddenly on February 21 at the age of sixty-three, as the result of epidemic encephalitis. Dr. Somers has been an outstanding figure in hospital circles on the Pacific Coast for many years. He was chief surgeon of the San Francisco Emergency Hospital from 1891 to 1895 and clinical professor of gynecology at Stanford University Medical School since 1911.

MISS WATERS LEAVES ASSOCIATION OF SOCIAL WORKERS

Lena R. Waters has resigned as executive secretary of the American Association of Hospital Social Workers to accept a position as head of the social service department of the Hospital of the University of Pennsylvania, Philadelphia. The resignation will take effect April 1.

No successor to Miss Waters has yet been named.

FORMER HEAD OF MOUNT SINAI'S CHILDREN'S DEPARTMENT DIES

Dr. Frederick L. Wakeham, retired specialist in children's diseases and for many years head of the children's department of Mount Sinai Hospital, New York, died March 4, at New Rochelle, N. Y. Besides being head of the children's department of Mount Sinai Hospital, Dr. Wakeham was formerly connected with Sydenham Hospital, New York.

THE OPEN FORUM

Thoughts, opinions and criticisms are invited for these pages from readers in all departments of hospitals and related services. Please address letters and other communications to the Editor, THE OPEN FORUM.

A SYMBOL OF HOSPITAL SERVICE

OUR editorial, "Insignia of Service," in the March issue has brought an enthusiastic response from the field. This is gratifying although not surprising because what human endeavor, what type of institution, what class of professional people, are more entitled to symbolism of their distinguished service than hospitals and their staffs?

The purpose of the editorial was to present the idea for the consideration of our readers, and we are pleased to quote below some of the comments that have been received. Many suggestions for such insignia were also sent in by enthusiastic executives and these will be used as a basis for the consideration of the design:

A. C. BACHMEYER, M.D., President,
American Hospital Association:

"I think the idea an excellent one and hope that it will elicit much interest and that a real emblem representative of hospital service will result."

S. S. GOLDWATER, M.D., President,
American Conference on Hospital Service:

"All words are symbols. The term hospital suggests many varied things to different persons; its mental associations are not the same even to hospital workers, but the central idea about which everything else clusters is the idea of generous hospitality to the sick. Hospitality to the sick is the very heart of the matter; it is the golden thread, a trace of which can always be detected in any legitimate hospital work, whether it be considered as purpose, plan, or result. I hope THE MODERN HOSPITAL will soon find the insignia for which it is seeking; I hope, too, that some means will be found to reward the happy discoverer of the appropriate emblem."

"Your editorial on this subject in the March number of THE MODERN HOSPITAL seems to suggest an emblem of an elaborate and complicated kind. I do not believe that the solution of the problem will be found in any emblem of that character. The most effective symbols, those richest in association and most productive in their emotional appeal, are usually extremely simple, deriving their abundant connotation and wealth of meaning not from cunning design, but from a happy association with some significant person or event. Perhaps we shall have to await the performance of some exalted act of hospital service by a modern individual, whose person or deed will thus suddenly and naturally come to typify to all the

world the beautiful character of hospital service. In the meantime, there can be no harm in attempting to create a symbol out of the known facts of hospital history."

REV. C. B. MOULINIER, President,
Catholic Hospital Association:

"The hospital insignia idea is a good one, but I should want to see the insignia before approving it."

REV. N. E. DAVIS, President,
American Protestant Hospital Association:

"Permit me to state that the 'Insignia of Service' is O. K. I am sure that some ingenious hospital superintendent will find the proper insignia in due time."

C. S. WOODS, M.D., President,
National Methodist Hospitals and Homes Association:

"I have read with much interest the editorial entitled 'Insignia of Service.' I am sure that the suggestion is a very happy one. It would seem that all of us together could evolve an insignia that should be entirely satisfactory to all the institutions. I am very glad indeed to cooperate in any possible way."

E. S. GILMORE, Former President,
American Hospital Association:

"I think it is a splendid idea for the association to have insignia and congratulate THE MODERN HOSPITAL for taking up the matter and pushing it along."

MERRITTE W. IRELAND, M.D., Surgeon General,
U. S. War Department, Washington, D. C.:

"I have read this editorial and am much interested in the proposal discussed therein to adopt an appropriate insignia for the hospital field. I am in accord with you in realizing the desirability of having such an insignia, and hope your researches may result in the development of an appropriate and distinctive device. I shall be glad to do anything that I can to help you in this matter."

E. O. CROSSMAN, M.D., Medical Director,
United States Veterans Bureau, Washington, D. C.:

"The medical service of this bureau will take pleasure in cooperating with you to the fullest extent in this matter, as, in its opinion, the proposed idea is not without considerable merit."

H. S. CUMMING, M.D., Surgeon General,
U. S. Public Health Service, Washington, D. C.:

"I have no hesitation in expressing my opinion that a proper insignia of service will be of great value for use

in the manner suggested in the excellent editorial in the March number of *THE MODERN HOSPITAL*.

"The officers of the Public Health Service assigned to hospital duty will, I am sure, be very glad to respond to any inquiries that you may address to them in helping to define the elements that should be represented in an appropriate insignia."

T. B. KIDNER, President,
American Occupational Therapy Association:

"I have read with very great interest the editorial in your issue of March, 1926, on 'Insignia of Service,' and am heartily in favor of the adoption of some heraldic device for hospitals and medical buildings that will symbolize their many-sided activities and their ideals."

"I believe it should be possible to devise a general symbol or emblem, but I think, also, that any special emblem or insignia that may be in use by the various groups interested in the hospital field should be retained. In practice, each group could use the general symbol, with a miniature of its own emblem attached to indicate its own special field."

"The American Occupational Therapy Association realized some years ago the need and value of a distinctive emblem, and devoted considerable time and study to devising the appropriate insignia which is now worn by its members."

"Personally, I feel that our members would welcome the idea of a general symbol; although I believe it would be wise and necessary to continue, at least for some years, the use of our own insignia; to be displayed in conjunction with the general symbol, as suggested above."

"I note with interest the list of various symbolic devices that have been considered for possible adoption; a list that indicates the great wealth extant of interesting lore dealing with this subject. I looked in vain, however, for some mention of an emblem that I have seen used on medical buildings in England; namely, the Liver bird, (pronounced lever)."

"This is the bird that figures in the coat of arms of the city of Liverpool. 'It was intended for the eagle of St. John, the Evangelist, the patron saint of the corporation, but owing to the unskillful delineation there have been many guesses as to the identity of the bird represented. In some ornithological books the name is given to the 'Glossy Ibis.' (New Oxford Dictionary). The same authority quotes from a seventeenth century work on 'Armory,' as follows: '.....this fowl is.....in Low Dutch Lepler, or Lepelear, or Lefler; from the Germane termed Lofler, which we more finely pronounce Lever.'"

"It is obvious, of course, that the precise significance of this symbol, like that of many others, is lost in the mists of antiquity. It is well known, for instance, that many Christian symbols or emblems were adapted from Pagan sources. As for its application on medical buildings, the only example that I ever had the opportunity of examining carefully was on an English hospital."

"As represented there, the bird was tearing its breast to feed its young ones; which appeared to me at the time (long ago) to explain sufficiently its emblematic significance of the sacrificial labors of physicians and nurses."

"Perhaps, however, some more learned correspondent of your journal will amplify and, if necessary, correct my remarks on this symbol."

MORRIS FISHBEIN, M.D., Editor,
The Journal of the American Medical Association:

"I have read with interest your editorial entitled 'In-

signia of Service.' The nature of man is such that he constantly seeks symbols to express his devotion and his ideals. I am not sure that such symbols do not serve a useful purpose, although it is well for some of us to recognize that they are but the symbols, and that the ideals are more important."

HENRY A. CHRISTIAN, M.D., Physician-in-Chief,
Peter Bent Brigham Hospital, Boston:

"I have read with much interest what you have to say about an insignia of service. I appreciate that an established insignia might have a large usefulness in the way that you indicate."

"After selection the only way that I can see to establish an insignia in use would be to get it adopted by hospital associations of one kind or another the world over as their insignia and get the constituent hospitals to begin to use it."

MABEL R. WILSON, President,
American Association of Hospital Social Workers:

"I think that the idea of insignia for the hospital field, if well worked out and carefully used, would be a very desirable thing."

JOHN A. LAPP, LL.D., Director,
Division of Social Action,
National Catholic Welfare Council:

"The idea of symbolizing the service of hospitals is a good one. We need to have before us an ideal, which a symbol or insignia of service will supply, in order to lift us out of the rut of daily work."

G. WALTER ZULAUF, M.D., President,
Hospital Association of Pennsylvania:

"I can see no valid objection to the use of an emblem symbolic of the work hospitals are doing, and believe if the proper design is chosen it would possibly react to their advantage."

WILLARD L. QUENNELL, M.D., President,
Michigan Hospital Association:

"I approve the idea of an emblem for the American Hospital Association. This could be used as identification of membership either on stationery or button."

NELSON W. THOMPSON, M.D., Secretary,
Hospital Association of New York State:

"I am very much in favor of an insignia for hospitals, emblematic of their work and I should be glad to take this up at the next meeting of the Hospital Association of New York State."

T. R. ZULICH, Superintendent,
Paterson General Hospital, Paterson, N. J.:

"An excellent idea. May the very near future provide a fitting and lasting insignia for the things worth while of which the hospital is foremost in its field of effort in behalf of humanity."

C. H. PELTON, M.D., President,
Ohio Hospital Association:

"I should be an advocate of such insignia being adopted. Details could be worked up later on."

REV. HERMAN L. FRITSCHER, D.D., President,
Wisconsin Hospital Association:

"The contemplated insignia should express something

definite and characteristic of hospital service. The medical profession and the profession of the nurse are to serve in close cooperation the public welfare in the institution for which this symbol stands."

J. M. SMITH, Secretary,
Hospital Association of Pennsylvania:

"I thoroughly believe in the idea and hope that it may develop because it is the nature of humans to respect and cherish insignia. The Red Cross the world over is symbolic of the greatest organization of nursing service that exists. The children in the first grade in school know what the Red Cross means. Undoubtedly this has a great deal to do with the stability of the organization and with the respect and admiration with which it is regarded.

"I believe that there can be developed an insignia symbolic of hospital service which after a few years will be just as well known and just as highly respected and honored as is the symbol of the American Red Cross. It will undoubtedly do a great deal to fix in the minds of the public the importance of hospital service."

FRANK E. CHAPMAN, Director,
Mount Sinai Hospital, Cleveland:

"The hospital field has long needed a symbol to designate its service. The ways in which such a symbol would be of value are too numerous to mention, but if one could be devised to typify hospital service it is my judgment that it would be decidedly beneficial to the field as a whole. I cannot but commend THE MODERN HOSPITAL in its desire to develop such a symbol."

JOSEPH C. DOANE, M.D., Medical Director,
Philadelphia General Hospital, Philadelphia:

"I think the idea of searching for an insignia that will symbolize the service of the hospital to its community is a fine one. It will be difficult to represent the humanitarian and practical aspects of hospital work in such a symbol but all hospital people will be benefited by the search, because in searching the aims and accomplishments of their own institution must be brought in review."

C. S. PITCHER, Superintendent,
Presbyterian Hospital, Philadelphia:

"I wish to congratulate the writer of the editorial and to second what he says concerning the efficacy of the insignia. Probably one of the great attractions of fraternal and secret organizations is their pins and the right to wear them.

"I believe the idea of adopting an insignia for hospitals is very meritorious. I am enclosing two prints of the insignia that was adopted by our hospital many years ago. We use this symbol on everything we issue, such as annual reports, bulletins and invitations. It has become a part of the hospital."

C. J. CUMMINGS, Superintendent,
Tacoma General Hospital, Tacoma, Wash.:

"I heartily approve the idea of hospitals adopting an insignia."

A. E. HARDGROVE, Superintendent,
City Hospital of Akron, Akron, Ohio:

"I agree that it is very desirable for the hospitals to have an individual insignia that would satisfactorily represent them and their work."

F. C. BELL, M.D., Superintendent,
Vancouver General Hospital, Vancouver, B. C.:

"A heraldic device that might adequately represent the various hospital interests seems a desirability for many reasons that rise readily to mind. In this connection it may be recalled that Carlyle saw in symbols not only a concealment but a revelation and that he has said 'in many . . . a simple seal emblem the commonest truth stands out proclaimed with quite new emphasis.'

"I suppose the commonest and most palpable truth about the work done in the hospital field is that it partakes essentially of service characteristically given in a willing, cheerful and generous spirit, but just how to symbolize that idea certainly seems difficult."

P. W. WIPPERMAN, M.D., Superintendent,
Decatur and Macon County Hospital, Decatur, Ill.:

"I think this is a splendid idea. I wish you every success and I am sure that, sponsored by your organization, such an insignia will be popular in the hospital field."

LOUIS COOPER LEVY, Superintendent,
Jewish Hospital, Cincinnati:

"An insignia that typifies the hospital would serve a useful purpose. Hospitals are monuments in the march of progress. They are erected and maintained in the cause of humanity and are an insignia in themselves.

"The editorial published by THE MODERN HOSPITAL conveys a thought that deserves serious consideration. An insignia has always been symbolic. The starred button worn by the World War heroes; the letters U. S. adopted by our government; the badges of fraternal organizations and countless advertising slogans made familiar to millions by publication and usage, have stamped the wearer as a member of the order or a part of an organization. The Red Cross signifies relief for humanity in times of war or disaster.

"Copyrighted and properly exploited it would have a meaning all its own."

C. C. HURIN, Superintendent,
Iowa Methodist Hospital, Des Moines, Iowa:

"I heartily approve of the movement by your splendid publication to have the American hospitals adopt a characteristic institutional insignia. Even the packer of beans has a trade mark that is known the world over.

"Hospitals have been much less fortunate in the spreading of their good will or of the good name of such institutions as you are vitally interested in. A symbol characterizing the work of the hospital should prove of inestimable value to all hospitals in this country."

C. W. MUNGER, M.D., Director,
Grasslands Hospital, Valhalla, N. Y.:

"I think it would be truly helpful if there could be some distinctive hospital emblem or insignia. An appropriate and expressive emblem is, of course, desirable, although in case such were difficult to find, I believe advantage could still be gained from a stereotyped emblem which in time would be understood by everyone to mean 'hospital.' I am sure that some of our resourceful and artistic hospital people can make appropriate suggestions as to design. Have you thought of the desirability, in case such a design is selected, of having it copyrighted or in some other way protected by the American Hospital Association so that it may not be used for commercial or other illegitimate purpose?"

GEORGE W. WILSON, Superintendent,
Hamot Hospital, Erie, Pa.:

"I heartily agree with the idea expressed in the editorial 'Insignia of Service' that appeared in your March issue."

N. W. FAXON, M.D., Director,
Strong Memorial Hospital, Rochester, N. Y.:

"I have read with a good deal of interest the editorial about the 'Insignia of Service.' It immediately struck a responsive cord in my mind. I should welcome the development of some such symbol."

SAMUEL G. ASCHER, Superintendent,
Miriam Hospital, Providence, R. I.:

"Relative to the 'Insignia of Service' appertaining to hospitals, may I say that after many years in hospital work, I see no reason why we cannot have some definite insignia of service. Any business, regardless of its line of endeavor, has some definite insignia. Hospitals, looking after human life, are in reality, in the highest type of business, and certainly are entitled to some recognition. I am heartily in favor of insignia."

ELMER E. MATTHEWS, Superintendent,
Wilkes-Barre General Hospital, Wilkes-Barre, Pa.:

"I sincerely think the idea has a great deal of merit as there should be some symbol that will especially mark hospital work. I also think it would be very helpful in calling the attention of the general public to hospital work."

ALICE P. THATCHER, Superintendent,
Christ Hospital, Cincinnati:

"This is such a novel idea to me. I scarcely feel qualified to pass judgment on it. However, my first reaction is favorable."

CAROLYN E. GRAY, R.N.,
New York:

"The editorial entitled 'Insignia of Service' is very fine and I am in hearty sympathy with what you are trying to do."

ELIZABETH A. GREENER, R.N., Superintendent of Nurses,
Mount Sinai Hospital, New York:

"I think that the idea of a symbolic emblem for the hospital field should prove both interesting and appealing to all hospital workers."

CHARLES N. COMBS, M.D., Superintendent,
Union Hospital, Terre Haute, Ind.:

"Hospitals have been so identified with the medical profession for the past hundred years that it had not occurred to me that another design was needed besides the caduceus. Although there is no urgency it will be worth while to have a number of keen minds searching for the proper insignia."

GRACE T. CRAFTS, R.N., Superintendent,
Madison General Hospital, Madison, Wis.:

"I think the idea is fine and the editorial excellent."

R. C. BUERKI, M.D., Superintendent,
State of Wisconsin General Hospital, Madison, Wis.:

"I have given thought to the need for a distinctive hospital insignia. I feel that your idea is a good one."

ROBERT JOLLY, Superintendent,
Baptist Hospital, Houston, Tex.:

"I am heartily in favor of having a symbolic emblem for the hospital field."

RICHARD E. SCHMIDT,
Richard E. Schmidt, Garden & Martin, Architects,
Chicago:

"I am very enthusiastic about the adoption of an insignia of hospital service, explained in the editorial of the March issue of THE MODERN HOSPITAL. I can see it as something that will symbolize hospital service and arouse greater and continued interest in and for it. There cannot be objection to it and the pleasure and benefits that it will give seem to be unlimited."

SAMUEL HANNAFORD & SONS, Architects,
Cincinnati:

"While the idea comes to us as something novel, we feel that the thought has considerable merit. The use of such an emblem would doubtless go far in promoting a community of feeling amongst those engaged in hospital service and in the allied interests dependent on and cooperating with them."

"We feel that THE MODERN HOSPITAL, because of its prestige, should take the initiative in the movement but assure you that if we can be of any assistance we shall be at your service."

WALTER E. LIST, M.D., Superintendent,
Minneapolis General Hospital, Minneapolis, Minn.:

"I am entirely in sympathy and accord with your idea relative to insignia for the hospital world and I furthermore agree with you that the insignia must cover the entire hospital as such, including medicine, care and feeding of the sick and professional hospital architecture. I hope that you will find something worth while that will represent the hospitals of the country and I wish you good luck."

W. P. MORRILL, M.D., Superintendent,
Columbia Hospital for Women, Washington, D. C.:

"There should be no question as to the importance of some such device as is advocated in your March editorial, and I hope that it will be possible to arrive at something as fitting as 'My Pledge and Creed.' It should, I believe, be somewhat more distinctive than, for instance, the golden circle of charity, expressing the healing idea rather than the charity idea."

PAUL H. FESLER, Superintendent,
University Hospital, Oklahoma City, Okla.:

"I think an emblem as suggested in the editorial in the March issue of THE MODERN HOSPITAL would be a step in the right direction and I endorse the idea heartily."

ADA BELLE McCLEERY, R.N., Superintendent,
Evanston Hospital, Evanston, Ill.:

"I like the idea of an insignia, if it can be safeguarded."

GEORGE F. STEPHENS, M.D., Superintendent,
Winnipeg General Hospital, Winnipeg:

"This question never appealed to me until a few weeks ago when occasion arose to have our 'mark' placed on some new silver. The hospital's corporate seal had too much detail for this purpose and no other emblem that we could think of seemed suitable, so we compromised on nothing. Since then I have done a good deal of thinking

so that your editorial was read with particular interest, not only for the thought brought out but for the delightful manner in which it was expressed.

"The conditions that surround the search for this symbol are suggestive of the 'Quest for the Holy Grail.' Emblems that at one time might have been appropriate are ruled out as unsuitable for universal use. The science and art of healing still remain, healing of both body and mind. This appears to me to be the only factor common to all hospital and allied workers."

GEORGE D. SHEATS, Superintendent,
Baptist Memorial Hospital, Memphis, Tenn.:

"I have long felt that this was a much needed symbol that could be applied to the entire hospital activities and become to the hospital field and profession what the caduceus is to the medical profession.

"It has been a satisfaction to me since the printing and distributing of your 'Pledge and Creed' to hear the favorable comments that are made.

"Once such a movement is started it will be but a short time before it gains impetus."

JACOB H. TRAYNER, Superintendent,
Idaho Falls Latter Day Saints Hospital, Idaho Falls, Ida.:

"The quest of THE MODERN HOSPITAL to find an insignia of service or a symbol 'that shall be the seal of the hospital world' is highly commendable and has our hearty approval and support. We trust that ere long the inspiration will be forthcoming that will provide the desired result of a crest that will prove acceptable and satisfactory to a majority."

FRANK E. BROOKE, Superintendent,
Harrisburg Hospital, Harrisburg, Pa.:

"Your idea of the adoption of an insignia of hospital service as expressed in the editorial in the March number appealed to me as meeting in a dignified way the need of bringing before the public the fact that hospital staffs are a people set apart for the care of their fellowmen. The insignia should be an actual symbol of the work in which we are engaged and should be suitable to be worn by worthy personnel as a badge of their service."

JOHN D. SPELMAN, M.D., Superintendent,
Touro Infirmary, New Orleans, La.:

"I sincerely hope that your effort to devise a coat of arms for the hospital field will be crowned with success. I hope that when the insignia of the hospital field is completed it will be copyrighted against misuse by undeserving institutions and also against its use in commercial advertising, as so many of our war slogans were a few years ago."

I. W. J. McCLAIN, Superintendent,
St. Luke's Home and Hospital, Utica, N. Y.

"It has often occurred to me that insignia of appropriate design for use by workers in the hospital field would promote interest and be a means of indicating worthy effort.

"Of course, the source from which insignia should spring and the means by which its dignity and purpose may be protected, and the adaptability of the general character of the insignia to include local significance, are points requiring considerable thought.

"I am pleased to know that the subject is going to receive public consideration."

HOSPITALIZATION OF PNEUMONIA CASES

A. K. HAYWOOD, M.D., Superintendent,
Montreal General Hospital, Montreal:

"In my opinion, it is wiser to have pneumonia cases, if possible, in the hospital. The only objection I can see to that, and at times I have noticed it to be a serious one, is the harm done by moving a patient during a critical part of the illness. I think one might go further and say that the moving of patients after illness is well established, is a serious matter. I am still old-fashioned enough to believe that one of the most important therapeutic measures we have in the treatment of pneumonia, is absolute rest."

WALTER M. HAMBURGER, M.D.,
Assistant Professor of Medicine,
Rush Medical College, Chicago:

"I am heartily in sympathy with the conclusions as contained in the report of the Chicago Pneumonia Commission. Substantially these precautions are being taken, both at Michael Reese and Cook County Hospitals, Chicago, on the medical service and although, of course, it is difficult at all times to be certain of the accuracy of this care, I feel it is highly desirable and should, wherever possible, be carried out."

HAROLD W. HERSEY, M.D.,
Superintendent, Bridgeport Hospital, Bridgeport, Conn.:

"The recommendations seem, on the hospitalization of pneumonia patients, sound, and while there might be some difficulty in carrying out all of these especially No. 1, in which the visitors to persons suffering from pneumonia would be prohibited, I believe that in so far as possible the recommendations should be adhered to.

"I am convinced that pneumonia is highly infectious and communicable and should be treated with all the precautions used in scarlet fever, typhoid fever, influenza and similar diseases.

"I believe that in many instances a fatal termination has resulted from moving a pneumonia patient to an institution for treatment, when this might have been avoided by not subjecting the patient to the strain of transportation and adjustment to a new environment. There is a point, however, where the home conditions may be so unsatisfactory as to warrant the transfer.

"Dr. Robert J. Lynch of our staff believes strongly that under no circumstances should a pneumonia case be subjected to the risk of transference from the home to the hospital even when the home conditions are most unfavorable. He states that the disease is highly infectious and communicable and that strict precautions should be observed by the person treating the pneumonia patient.

"Dr. H. LeBaron Peters of our staff makes the following statement:

"I feel that on the whole the suggestions are good. I do not feel that patients should be moved to the hospital except under exceptional circumstances after the fourth day.

"Cubicle and ordinary care with regard to transmitting infection should be carried out in all cases. In the absence of cubicles, pneumonia should be segregated to a greater extent than typhoid fever, in fact, with regard to isolation it should be treated with the same care as tuberculosis."

HOW THE LAKESIDE DISPENSARY MORE THAN DOUBLED ITS CAPACITY

By Russell B. Williams,
Chicago

FOUR years ago the Lakeside Hospital of Cleveland found it difficult to handle one hundred out-patients a day. Now it gives service to an average of 250 a day, and can handle 400 without inconvenience. This increase was effected through some minor readjustments in the reception room, the erection of a balcony that adds about 540 square feet of floor space, a certain amount of professional reorganization and the installation of a small chute, a tiny belt elevator and a telautograph.

Lakeside's dispensary occupies an entire three-story building, the facilities of which are quite adequate for the class of service demanded. Prior to 1922 all out-patients were required to present their cards and fees at one central desk in the reception room. Behind this desk, or counter, were stationed the admitting room, a doctor, the social workers, and several of the clerical personnel.

In spite of every effort toward orderliness, on days when upwards of one hundred patients visited the dispensary it was quite apparent that the facilities were inadequate. The visitors were constantly waiting in the

reception room with the result that there was confusion, duplication of effort, a high percentage of mistakes, and considerable misunderstanding. Under such conditions little efficient social service work could be done and not infrequently needed attention was too long delayed.

With the growth in demand for service came the realization that something must be done to accommodate the patients better and to raise the standard of service. Funds for a new building were not available and it was therefore decided to rearrange the physical properties of the reception room.

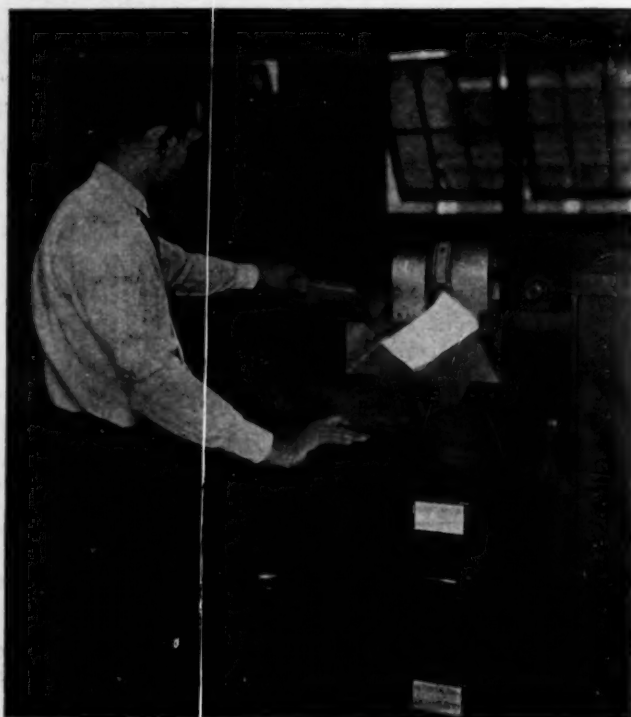
The first step was the removal of the general reception counter to a mezzanine. On this mezzanine were placed all history files and desks for the clerical personnel. Directly in the center of the reception room was installed a small desk at which the admission clerk works. This desk is elevated above the floor about six inches to give it prominence.

In front of the outside door there is a small booth built after the fashion of a ticket sellers' booth at a theater.



The installation of mezzanine has lifted files and clerical work from the congestion of the main floor. The telautograph as well as the belt elevator and chute can be seen in the picture.

In this booth, which is really only a rectangular counter, sits a clerk at the telautograph, and a man who serves as cashier and who gives verbal directions. From the clinic cards the clerk records on the telautograph the name of the patient, his number and the department to which he is going. The visitor is then told to proceed to



View from the mezzanine showing the upper end of belt conveyor and chute. As the patients enter the dispensary at the front door telautograph requests for charts come to this desk.

his department. In nearly every case he finds that his chart has arrived before him. In the department he finds the social worker and a doctor. In this way more than 400 patients can be cleared through the dispensary in three or four hours.

The new arrangement and general layout of the reception room and entrance corridor were governed by the results of a scientific analysis of patient travel. The distance between each desk has been carefully determined by accurate calculation of the time required by each patient to transact his business and move on to the next desk. For the sake of clarity and simplicity let us accompany an imaginary case through the dispensary.

Patient Psychology Considered in Layout

Mr. Smith, let it be supposed, has come to the clinic for the first time, his complaint being eye trouble. The lids are granulating and he requires glasses. Mr. Smith, being unfamiliar with the place, steps into the line directly in front of the telautograph desk, that seeming to be the thing to do. When he reaches the desk he is asked for his card. As he has none the cashier inquires if he has been there before. He gives a negative reply and states he would "like to see a doctor." He is immediately directed to the desk some twenty feet down the corridor.

He proceeds to this desk and here finds a doctor, to whom he outlines his trouble. He answers a few questions and the doctor then supplies him with a little card (2"x 2") on which is printed a numeral. He is also given a slip of paper, of about the same dimensions, on which

is stamped "Eye." Armed with these two slips he is told to take a seat in the main reception room and await the call of his number.

The psychology of this procedure is perfect. Mr. Smith came to the dispensary "to see a doctor." He didn't come to see a clerk or to pay out money. The latter he is willing to do, but first he wishes to consult a doctor. At Lakeside this is precisely what he is allowed to do. He is not stopped at the front desk, but is permitted to proceed immediately to the diagnostician. Without conscious analysis Mr. Smith feels that the process of healing has already started since he has actually seen a doctor.

In the course of a few minutes the girl at the central desk calls his number, whereupon Mr. Smith presents himself. This girl is the admitting clerk who takes the name, address, department indicated, and all other routine information needed for the start of a chart. She requests, at the same time, the payment of the twenty-five cents admission fee. Having received this she directs Mr. Smith to the eye department, telling him just how to go.

How the History Is Transported

The admitting clerk slips the preliminary information sheet into one of the clips on the elevator belt that carries it to the balcony. Here it is received by one of the typists who clears the name through the index to determine whether the family has been previously listed for treatment. She then transfers all information to a regulation chart envelope, assigns the patient a number and makes all records. The chart is then chuted back to the table, where are four girl pages. One of the pages takes the chart directly to the department in question (in this case the eye department).

When Mr. Smith is requested to come into the clinic by the social worker she has his chart in hand. Provided with this she does not have to ask his name and address, but proceeds immediately with her work of determining his social and financial status. If everything is satisfactory the social worker refers the patient to the attending physician who starts treatment. Upon leaving, he is instructed always to bring his card when he returns, the card having been made out by the clerk and transmitted to the clinic with the chart envelope.

At his second and subsequent visits, Mr. Smith presents his card at the telautograph desk, where his name, number and department are transmitted to the mezzanine by means of the telautograph. From this machine tape the file clerk on the balcony extracts the required history, clips to it a slip rubber-stamped with "Eye," chutes it to one of the pages below, who takes it directly to the clinic. With blue pencil the clerk checks the tape from the machine, thus indicating that history number so-and-so, for Mr. Smith, is in the "Eye" department.

At the close of the day the history file clerk checks the histories that have been returned with the telautograph tape. All histories not returned are instantly noted in this way. Since the front door girl has written the department as well as the name and number when she requested the history earlier in the day, the file clerk has definite information as to just which department is holding the chart. She is thus in a position to tell a page that the such-and-such department still has seven histories. The page then goes for them, securing in their stead (if for some reason they are to be retained) a written receipt signed by the one holding them.

A recent check on all activities of the front desk disclosed the fact that twenty-three patients were cleared through the first desk in six minutes. This is slightly under four patients a minute. In every case, the his-

tories were found to have been delivered to the clinic before the patient reached that clinic.

This tremendously increased speed was made possible by three major adjustments. First, the lifting of the histories and clerical work to a mezzanine; second, the installation of a telautograph and, third, the installation of a metal chute and a belt elevator, the latter being operated by a quarter-horse power motor which was completely installed at a cost of \$36.00.

Few charts are lost since there is a very definite check on each one from the machine tape. Considerably more satisfaction is expressed by the patients since they are accorded more individual and much more prompt service.

One of the clinics being on the second floor of another wing of the building, an ordinary cash carrier has been installed from the balcony to the receiving desk of the clinic for the transportation of the histories.

This article takes into account only the visible and mechanical improvements, and in no way enters into the professional reorganization which doubtless contributed largely to the increased efficiency and patient attendance. Probably Lakeside was admirably suited to the acceptance of the readjustments made. However, this experience would be necessary.

IMPROVING FOOD SERVICE IN MENTAL HOSPITALS

Surveys of food administration and of nutrition education in many residence schools and in hospitals offer convincing proof that the failure of food departments to function smoothly and effectively is due not so much to inadequate salaries as to lack of training of the personnel for their specific duties, and in failure to centralize responsibility for results. The solution lies in bringing all food activities of an institution under one person qualified by training and experience to take charge of both the scientific and the administrative phases of the work.

Great care must necessarily be exercised in the selection of this person, since such an executive should be endowed with a spirit of cooperation, with broad vision, executive ability, tact, and sympathy for the sufferings of others. A woman, except in rare instances, is better fitted to fill such a position than a man. She has greater aptitude for handling foods. She has a mind for detail and a sharp eye for small economies which a man does not usually possess. This matter of small economies is not one to be lightly dismissed; for if a food department is to give satisfactory service and at the same time keep within its budget, economies must be effected in small as well as in large matters.

There is another factor which makes the choice of a woman as food administrator preferable to that of a man. Many mental patients come from cultured homes, and are accustomed to esthetic environment. The drabness of most state hospitals and the lack of pleasant surroundings reacts unfavorably upon the patient. On the other hand, patients of the higher mental type react most encouragingly to walls painted in light, restful tones; to bright flowers for table decorations; and to rhythmical, harmonious music during the meal hour. A woman as food administrator, is more likely to give special attention to making the environment attractive and restful. She will appreciate the importance of segregating the patients with good table manners from those whose manners are repulsive; and of grouping the patients of higher mentality in an attractive dining room by themselves.—Katharine A. Pritchett, in the *Nation's Health*, February, 1926.

PROVIDING FACILITIES FOR SURGICAL TUBERCULOSIS

Recently, surgery has entered greatly into the treatment of pulmonary tuberculosis. Certain types of the disease, formerly hopeless, have yielded to artificially induced pneumothorax applied by the unilateral, the alternate bilateral or the partial simultaneous bilateral methods. Extrapleural thoracoplasty, injection of oil and phrenicectomy have likewise prolonged and possibly saved many lives. Together with this advance in treatment has come the problem of making surgery available to those who require it without endangering others. One body of authority asserts that "there is some risk in living in the same room even with a careful consumptive," and that treatment of tuberculosis in general hospitals should be avoided so far as possible unless special wards are provided for the patients. This opinion is supported by a few of the specialists to whom Dr. Adolphus Knopf recently sent a questionnaire.

On the other hand, the great majority of those who replied to this questionnaire, together with Dr. Knopf himself reinforce the belief of Dr. Willy Meyer that although children may become infected from tuberculous patients, there is practically no danger to adults of contracting the disease in hospitals. Dr. Meyer asserts that scarcely ever has a healthy physician, nurse or employee of a tuberculosis hospital or sanatorium contracted the disease.

Here then, is the necessity of balancing benefits of compromising with the ideal and attaining the practicable. Tuberculous patients requiring surgery cannot wait. Many sanatoriums, furthermore, are not equipped, either in personnel or in operating or nursing facilities, to give their patients the requisite surgical treatment. Until sanatorium space is adequate and until sanatoriums possess sufficient surgeons and surgical facilities, surgical wards in general hospitals must be made available to those tuberculous patients to whom operation means a chance to live.—*Journal of the American Medical Association*.

JOINT COMMITTEE ORGANIZED TO PROMOTE BETTER OBSTETRICS

The joint committee, representing the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, the American Child Health Association and the American Gynecological Society has organized a nationwide campaign to present the appeal for better obstetrics, more definite prenatal care and rigid asepsis.

Through state chairmen of groups of lecturers who will, upon request, furnish speakers for meetings, the joint committee hopes to present a program on maternal welfare in every medical society in the various states.

Originally it was planned to include in the joint committee representatives of the section of obstetrics, gynecology and abdominal surgery of the American Medical Association but owing to the annual change in personnel of its officers and the fact that no provision can be made for the financial support of the committee this was thought by the officers of the sections to be impracticable.

One of the most vital problems which the committee must help to solve is the early reduction of risk rate to mothers in child-birth. It is believed that the program outlined by the joint committee will reduce by fifty per cent our present risk rate to mothers in childbirth at home and in the hospital.

HOSPITALS AND ESTHETICS*

WHAT we might call the mortal life of an architectural design ends with its crystallization into the three dimensions of the finished structure. With its resurrection in brick, stone and steel, comes the final severance of the created thing from the constructive imagination of the designer. In happy instances, it may also mark the beginning of an honored immortality. But in any event, the investigation and study of a completed building is from the point of view of the architect really an academic question—a kind of pathologic study—and in the case of a hospital, an affair most appropriately conducted by medical experts. Therefore, I shall confine my attention to a single phase of this architectural problem, a phase of great, though I believe, insufficiently recognized, value in all hospitals. It affects that human side of every hospital problem so well epitomized in the sentence suggested for the entrance of the Virchow Hospital in Berlin, "In treating the patient, do not forget the man."

The esthetic phase of the problem of the modern hospital is ordinarily considered as of minor importance and as pertaining to the point of view of the patient only, as differentiated from that of the institution. That this is a distinction without a difference should go without saying; though, as a matter of fact, there still exists both within and without many hospitals a general impression, or misapprehension, that of the patient as contrasted to that of the institution, and that the best solution to be hoped for is a compromise between them.

Meet Demands with Harmony

However this may be, the prime requisite from the esthetic point of view is that these institutional demands, and many others not here mentioned, should be met with complete harmony, without architectural disturbance; that all the various facilities, clinical, research, teaching, be so comfortably housed under one roof that they may all present their most agreeable aspect to the stranger who enters their household, to the student and teacher no less than to the patient, in one sense, the guest of honor.

And first, with particular reference to this question of esthetics, I want to speak of those so-called two points of view, that of the institution and that of the patient, and their apparent divergence when the hospital problem is looked at in certain lights. No one, I think, of all those concerned in the matter of hospital design, trustees, doctors, superintendents, nurses, students, or patients, has such a comprehensive and unbiased view of all its aspects as the architect.

After many weeks spent in visiting institutions throughout Europe, the impression made by the ward of a recently completed hospital in London still stands out vividly in my memory. The room was rather low ceiled, and made no architectural pretense, but the sunlight came through prettily dressed windows and fell on stands of flowering plants, while the reflection of a brisk open fire danced on a dark polished floor. And lying in brass knobbed beds, crisp and fresh against warmly tinted walls, the patients themselves provided a finishing touch of cheerfulness by wearing bed jackets of hunting pink. It was positively festive. In the midst of smoky London, and in the heart of a great institution, it gave one a shock of pleasant surprise. My first impression was that we

had made a mistake; and the next, that if we were really by chance in a public hospital ward I should be more content to be ill under such conditions than well in most other rooms in London. Of course, I knew better than that; but such was the mental reaction, distinct and immediate, and in radical contrast to experiences in a hundred other wards.

While a hospital is obviously and essentially a place to get out of, it should equally be a place into which the sick man is eager to go; and the presence of one and the same quality in the building would aid materially, I hold, in producing both these desirable characteristics. And it is of this "quality" and the relation it bears to all hospitals, and their design, that I shall now particularly speak.

Viewpoints Must Be Identical

The first and very obvious fact is that while there must always be institutions as well as a public to serve, there can be no longer two different points of view. The interests of the two always are and have been, of course, identical. The trouble has been rather with the eye-sight—a matter of astigmatism, or, more accurately speaking, "double vision," fortunately of the kind that decreases with the years, as its causes are eliminated. But its genesis in the case of the patient is historical and dates back to the days of Bedlam and the Hotel Dieu, the days of chains, strait jackets and pens, and of four, or even six in a bed. And all this, let us remember, only a few generations since. Let us acknowledge then at the start that the hospital has a gruesome reputation to live down, however undeserved it may be today. That the inheritance was partly bred of ignorance and superstition is immaterial. As a matter of fact, to a certain extent the masses still have a tendency to mistrust and fear.

After all, taking a man out of his home, however poor it may be, is transplanting him, and means that he must find himself again in the new environment. The sheets of the hospital bed are cleaner, even finer, perhaps, than his own; but he has got to warm them up, nevertheless, before he can relax between them.

Color Sense Makes Strong Appeal

After the patient is warmed and fed, the sense of color may quite conceivably make the strongest appeal for gratification. And what is there in the conventional to gratify it? The answer is "complete asepticism"—glistening tile, white marble and glass, nickel and enamel paint, iron furniture, windows without curtains, mechanical ventilation, invisible convected heat to the exclusion of the radiant open fire, or even the reddening stove. And on all sides our friend the gray flannel bed jacket! Perfect asepticism, with not a germ in sight, in some cases, not even the germ of comfort.

Such conditions are, I think, already changing; but a ward designed with any real esthetic consideration is still rare. And such consideration when it happens at all is largely superficial. Given the size, shape, and general character of the room as determined on the lines of the most efficient service of the doctor, nurse, and orderly, the architect is indeed permitted to make the best of the conditions. But his treatment of the problem must not involve additional expense, either in first cost or upkeep. So that any stray element of beauty that may find lodg-

*Abstract of the article "Hospitals and Esthetics," by Grosvenor Atterbury, F.A.I.A., A.N.A., published in the January, 1926, issue of *The Architect*.

ment in the crackless walls of efficiency and asepticism is most often a hazard of fortune, a by-product at best of the architect's design.

The whole matter of asepticism, including the question of glistening tile and paint, I am going to leave to physicians, for I expect a certain amount of sympathy in their attitude in this matter. I have been secretly advised that because certain conditions in hospitals are general, they are not necessarily right; that possibly the aseptic pendulum has swung too far; that cold, white walls, even in the operating room, may be a mistake, from an entirely practical point of view. And as I reflect with what shocking clearness the dust shows on our black piano lid, I wonder if the physicians are not right, and take courage afresh in consequence.

But even against minor reforms, the efficient hospital superintendent will probably protest. From his point of view all these homelike things complicate matters; even walls of good texture and pleasing variety of color throughout large buildings mean trouble and expense in redecorating. And after all, he says, while you and I appreciate such things, the average patient would never know the difference. And herein he has usually been backed up by his board of trustees.

This is their manner of saying that the sense of beauty is a cultivated, not a natural, sense; or, if natural, then at any rate, a negligible one. Whether this does not put the cart before the horse, the sense of beauty being the vital, moving cause of all culture, is not to be discussed here; nor is it perhaps worth discussing at any time. But we are very presently concerned with the practical consequences of a theory that teaches that while the senses of heat and cold, of smell and hearing and touch, are to be reckoned with and respected like all other bodily functions, the sense of sight needs no consideration; that the eye can protect itself.

Existence of Form Appreciation

Of course, I am not considering those niceties of value, color and form that one ordinarily correlates with the words "esthetic" or "artistic"; nor of architectural scale and design where the case is less obvious than in the matter of color. The appreciation of form is higher up in the scale of perception. But because we have not yet recognized its presence except in the so-called cultured human being is no proof that it does not exist, even in the average hospital patient.

Again, the attempt to capitalize the glow of the open fire and the brass knobs on the beds may be challenged as far-fetched. But think for one moment what the world does to satisfy the esthetic instinct of mankind. Are the billions spent annually for such purposes merely colossal extravagances—simply unrelated madness exhibited by nine-tenths of the human race? For centuries, the Church has known and used art to the utmost—music, incense, stained glass windows, wondrous architecture—as a mighty aid in her work of exaltation. Why then should medicine not admit esthetics to the hospital?

It has happened that among all the new hospital conditions that have combined to make the radical advances since the days of Bedlam and the old Hotel Dieu, one looks usually in vain for the esthetic element—a consideration of the sense of beauty. With rare exceptions, the only real esthetic touch in our great hospitals is an accidental one, the trained nurse in her cap and gown; and I venture to say that, considered merely as a piece of decoration, she has done more than any other one thing to counteract the blight of the institutional atmosphere.

The Æsculapian temples of healing were shrines of

beauty. Should we then consider the modern hospital as nothing more than a huge shelter provided for the surgeon's, physician's and nurse's work, as an esthetic workshop furnished with power and machinery, the latest tools and the most perfect equipment and scientific aids to research and clinical efficiency, merely a complex of convenience and apparatus? Or can we consider it not merely a great mechanism, but a silent agent in the art of healing?

Am I wrong in thinking that, after all, the most perfect hospital is the one which most nearly satisfies the requirements of that master of all consultants, Nature, and that diagnosis, operation, treatment, research, are all but a seeking to find the way of least resistance through which Nature shall work? And if this is so, can we afford to neglect the least helpful thing, even though we believe others more important?

ATTRIBUTES OF SUPERVISING ANESTHETIST

Isabella C. Herb, M.D., chief anesthetist, Presbyterian Hospital, Chicago, in a paper on "The Anesthetic Problem in Its Relation to the Hospital," states in part: "To be successful, the head of the anesthetic service must not only possess a comprehensive knowledge of the subject but must have qualities of personal integrity, a stimulating personality and must have the cooperation of the surgical staff.

"The anesthetist who possesses tact, sympathy and a reassuring personality, is a definite asset, not only to the surgical department but to the hospital that claims him as a member of its staff. The influence that such an individual exerts is felt throughout the institution. It is passed from physician to nurses, from nurses to patients, and from patients to friends, with the result that a confidence is established before the patient goes to the operating room. Naturally the fear of the anesthetic is lessened if not altogether abolished.

"It is perhaps needless to add that the supervising anesthetist must be a member of the hospital staff in order to maintain proper discipline among the interns; furthermore, he must be a physician or quite naturally his knowledge will be questioned and his instruction resented. It is a misfortune as well as an injustice to interns to have a lay person in charge of the anesthetics. Medical graduates rightly feel that it is retrogression to be taught medicine by a non-medical person."

AN EXAMINING DEPARTMENT—NOT A LABORATORY

The roentgen ray department is not engaged in work of a kind in which the answer to the problem is found by looking up certain formulas or watching for the development of certain reactions; for the reactions when obtained, that is, the film or screen image, still require interpretation, writes Dr. James T. Case of Battle Creek, Mich., in a recently published article. This takes the roentgen ray work out of the general class of laboratories and puts it among the examining departments, such as the urologic, ophthalmologic and electrocardiographic.

Indeed, it might be better if the term "roentgen ray laboratory" were abolished and we spoke of the "roentgen ray department" or the "roentgen ray examining department." The primary object of a roentgen ray department is not to make "pictures" but to supply information.

SIMPLIFYING STOREROOM PROCEDURES

By D. Adams, Steward, Jefferson Hospital,
Philadelphia

THE department of purchase and issuance plays an important part in the various activities of a large hospital. When well managed it greatly enhances the efficiency of the institution and is a factor in keeping down per capita costs.

In successfully administering this department it is essential to have a well planned and equipped storeroom with spacious refrigerators. The storeroom should have steel shelving, if possible, also bins constructed of steel or metal, with doors, either solid or of glass to keep the stock free from dust and moisture so that it can be arranged and kept in an orderly manner.

This is especially true of the stationery and printed forms. These can be kept in bins with the form numbers on a small slip over each bin, which arrangement enables one to locate easily any kind of printing in the stock, by using an index chart of location, that can be kept in the office of the storeroom.

A set of standard scales should be kept in the receiving room of this department, near the refrigerators, so that all food supplies bought by weight can be carefully weighed and checked on the invoice at the time of delivery.

In many hospitals it is found advantageous to divide the food supplies as follows: bread, milk and cream, butter and eggs, groceries, fruit and vegetables, meat and fish, poultry.

Comparisons of quantity and the cost of each division of food for any given period can be made readily, thereby

enabling one to know if supplies are used economically and thus control expenditures.

In making purchases of food supplies, it is essential to keep in touch with the market and buy in large quantities when the prices are favorable, thereby affecting considerable economy.

In the purchase of other supplies, such as gauze, sheets,

JEFFERSON HOSPITAL
COMPARISON of COST of FOOD SUPPLIES for MONTH of

	1924	1924	1924	1925	1924	1925	1924	1925	1924	1925
	General Hospital	General Hospital	Dis. of Chest	Dis. of Chest	Maternity	Maternity	New Building	New Building	Total	Total
Bread	406.87	397.73	39.53	35.85	17.14	23.98	71.87	160.56	537.61	823.96
Milk and Cream	1444.56	1254.67	143.68	180.78	71.42	119.65	387.63	925.14	2047.29	2479.24
Groceries	1094.33	1127.85	90.44	90.01	60.30	101.99	351.12	736.40	1686.19	2056.28
Butter and Eggs	1820.56	1697.91	74.47	104.43	70.22	143.73	354.66	1001.44	2019.93	2946.91
Fruit and Vegetables	1034.12	1003.72	64.20	60.65	53.59	100.32	286.93	861.18	1428.84	2025.85
Meat and Fish	1337.20	1424.30	129.98	140.61	79.35	157.42	377.77	1159.03	1964.30	2881.66
Poultry	617.55	503.89	25.28	38.60	36.14	69.34	315.09	813.65	994.06	1425.45
Total	7497.19	7410.09	657.68	651.83	378.16	719.83	2145.09	5656.40	10578.02	14438.15

Total patient days in all departments	13035	15226
Total patient days in General Hospital	10357	10139
Total patient days in Dept. Diseases of Chest	1154	1143
Total patient days in Maternity Department	495	1308
Total private patient days (New Building)	1029	2616
(Old Building)	2491	2234
Average private patients per day	117	162
Average patients per day for all departments	435	508
Average patients per day in General Hospital	345	336
Average patients per day in New Hospital	34	87
Average patients per day in Dept. Diseases of Chest	38	38
Average patients per day in Maternity Department	17	43
Average expenditures per day for all departments	352.60	481.27
Average expenditures per day in General Hospital	249.90	247.00

Sheet used in comparison of monthly food costs of successive years

pillow cases, blankets, gowns and pajamas, it is necessary that the buyer familiarize himself with the conditions of the cotton market. The purchasing agent should be amiable, and able to glean information from every salesman.

In issuing supplies from the storeroom it is necessary to use a requisition form on which the stock required is properly listed. These should be signed by the floor nurses and countersigned, or approved, by the directress of nurses or someone designated by the executive of the hospital before they are sent to the storeroom office. If for food, they should be signed by the chief dietitian. After the requisitions have been filled, they are sent to the book-keeping department of the storeroom where they are priced, computed entered on the books and charged to the department from which the requisition has been issued.

In order to simplify and coordinate the work in the storeroom it is advantageous also to designate the day on which certain supplies will be furnished, thus:

Monday: Bed linens, tape, cotton, gowns and pajamas
Tuesday: Dishes, water pitchers, silverware, cooking utensils
Wednesday: Housekeeping supplies
Thursday: Stationery and printed matter
Friday: Surgical and medical supplies
Saturday: Food supplies only*

*Food requisitions are filled every day.

NO. 14033 JEFFERSON HOSPITAL DATE 7/19/24
REQUISITION ON STOREROOM. FOR USE IN

REQUISITION MUST BE APPROVED BY HEAD OF DEPT. AND BE COUNTERSIGNED BY THE STOREROOM OR SUPERVISOR.

QUANTITY ON HAND	QUANTITY WANTED	DESCRIPTION	PRICE	CURRENT
		1/2 doz. Safety Pins ✓		
		1 doz. Paper Towels ✓		
		1/2 doz. Starch Covers ✓		
		1/2 doz. Dressing Covers ✓		
		1/2 doz. Couch Covers ✓		
		4 doz. Orange ✓		
		1/2 doz. Lemons ✓		
		1/2 doz. Eggs ✓		
		1/2 doz. Saltines ✓		

APPROVED: *William Campbell* (Signature)
APPROVED: *Nathaniel Campbell* (Signature)
APPROVED: *L. M. Mable* (Signature)

NO REQUEST FOR SUPPLIES WILL BE HONORED UNLESS THIS FORM IS USED

Requisition blank with each item properly listed and approved by department head

[illegible]

Form used in keeping a perpetual inventory of the storeroom stock

It has been found valuable to have certain used articles, such as mops, brooms, floor brushes, ice caps, hot water bottles, returned before new ones to replace them are issued.

It is advisable, in large hospitals, to keep a perpetual inventory of the storeroom stock. This will enable one to know at any time the amount of supplies used, by what department; also the balance on hand. At the Jefferson Hospital, seven hundred fifty different articles are listed in the storeroom summary, and careful accounting is necessary to keep a correct record of all transactions in a hospital of this size (635 beds).

However, it is a source of great satisfaction to the administrator and profitable to the institution to have this information so that it can be used to check costs and control the use of supplies.

This hospital is greatly indebted for valuable information obtained from time to time from the committee on accounting and records of the American Hospital Association, under the chairmanship of Dr. A. C. Bachmeyer.

MAINTAINING AND INCULCATING SELF-RESPECT

By Eleanor J. Ford, R. N., Director, North End
Community Clinic
Detroit

About fifteen years ago there was active discussion regarding a plan of relief being tried by the leading charity organizations in the country.

Up to that time it was a common practice for social workers to accompany members of dependent families who were making purchases and to bespeak from the sellers consideration for their financial plight. Reduced prices, or free gifts of food and clothing were asked for because the family was in financial need. The landlord was approached in the same way. Every family applying for relief by this method was more or less stamped in the neighborhood as an object of charity, an embarrassing

situation for self-respecting people who had met with misfortune, often through no fault of their own.

More than a decade ago the most thoughtful social workers made the suggestion that for the sake of the future of these people this plan should be radically changed. The amount of money necessary to feed, clothe and house them should be given them and they, in turn, should be allowed to purchase the necessities of life without any visible supervision, so that no one in the neighborhood or with whom they dealt need know they were receiving financial assistance.

The plan met with tremendous opposition. The majority of people were sure that any one so improvident as to fall below the independent line could not be trusted with money to make their own purchases. It was in the days of saloons and the statement was frequently made that instead of buying food and clothing and paying the rent the money would be spent in the neighborhood saloon. Today all of this seems very odd, almost amusing, for the policy has been so generally accepted that one has almost forgotten any other plan ever obtained.

I have wondered why for the same psychological reasons the cost of medical service was not included in the plan. If it hurts one's self-respect to be accompanied by a social worker who asks reduced prices or free gifts from grocers, other merchants and landlords why does not the same hold good if one is accompanied or sent to a dispensary or doctor's office? Would it not be better for the families of relief agencies who come to clinics to come there with the necessary quarters or half-dollars or whatever the fees may be, so that they would not have placed upon them the stigma of being charity cases and, what is even more important, so that their self-respect might be conserved and the habit of paying for service received, cherished, or inculcated if previously absent? If they are taught the value of this service and pay for it in cash, after they become self-supporting would they not continue to pay for what they receive in this line? As they become more affluent would they not more readily take the next step of going as private patients to physicians' offices?

PHYSIOTHERAPY IN GENERAL HOSPITAL PRACTICE*

By Arthur E. Schiller, M.D.,
Detroit, Mich.

THE practice of physiotherapy in a general hospital offers a number of peculiar and very distinct problems. No hard and fast rule can be promulgated that will cover all the requirements, but a general comprehension can be gained by the study of the problems of individual hospitals. Most important is an understanding of the necessity for a physiotherapy department in a general hospital. The conclusion drawn from a survey of the published opinions of English and Continental hospitals is that physiotherapy is of such importance in the welfare of the patient, that ever increasing space is given over to this branch of treatment.

We point to the enlarged Finsen Institute in Copenhagen, where the tuberculopathies are so admirably handled by the use of ultra violet energy derived from the carbon arc lamps. In Germany and Austria the spas and cures have for many years demonstrated the value of hydrotherapy. In these same countries diathermy and the use of the electrical currents have been so vigorously exhibited that the published results would make the uninitiated reader gasp and question the veracity of the writer.

Cumberbach has for years been in charge of the department of electrotherapy in St. Bartholomew's Hospital, London, England. His published work is conservative and the evidence gathered over a long period demonstrates, beyond the question of a doubt, the value of electrotherapeutic measures in general hospital work. In our own country the experiences in rehabilitation camps and reconstruction hospitals during the early post-war period proved to us its value and laid the foundation for American physiotherapy. The efforts of a small group of earnest men furthered the interest of this branch of therapeutics and under their supervision were trained the men who were to place these measures in the hospitals and thus at the command of the entire medical profession.

Manufacturers Build Needed Types

Actuated by self-interest, the apparatus manufacturers rendered the profession a great service by building apparatus of the types necessary for the various measures in use. Constant improvement and the elimination of unsound practices caused further changes until apparatus that was essentially practical and simple was manufactured. The universities and colleges, by adding chairs of physiotherapy to their curriculum, are now answering the demand for men trained in physiotherapy.

It is my opinion that hospitals, by equipping themselves with apparatus, technicians and trained men should lead the way in this movement of the application of mechanical and electrical measures to the practice of medicine. The hospital that does not do so loses the opportunity of a complete service both to the physician or surgeon and his patient.

The next question that naturally might be asked is, "What are the most important modalities used in physiotherapy?" The answer depends, of course, upon individual experience. In my opinion, the following are the most important in order of telling—ultra violet ray therapy, diathermy, the continuous currents, the alternating currents, the last three being combined under the general

heading of electrotherapy, roentgenotherapy, hydrotherapy, and mechanical manipulation such as massage and corrective exercise.

The hospital that is preparing to treat cases by physiotherapy should approach the subject of equipment in the manner of the Chinese philosopher, namely, with the all-seeing eye, the attentive ear, and the questioning spirit, because all too frequently we see departments organized by physicians and equipped by the advice of glib-tongued salesmen who are more interested in the selling of a large bill of goods than in the actual needs of the hospital. Basing the requirements on the prospective needs of a hundred bed hospital, I think the following equipment could be used to advantage:

1. Ultra violet ray.

(a) *Air cooled.* It is almost necessary to have two of these lamps since both will be in use most of the time.

(b) *One water-cooled,* or Kromayer type lamp is necessary for use in the treatment of infected wounds and wherever the bactericidal effect of the ultra violet ray is necessary.

(c) *Finsen lamp.* This can be used to advantage where the space is allotted for it and where a trained aid who understands the lamp may be had to run this piece of equipment.

2. Heat, or deep therapy lamps.

(a) Two large 1500 watt heat lamps and two small 500 watt, portable lamps for ward work will fulfill the requirement.

3. Diathermy.

(a) Two machines on carts, capable of giving at least 3,000 m. a. on a direct short, together with the necessary cords, pads, applicators, block tin, clips, bandages.

(b) To this may be added a combined endothermy and coagulating machine for surgical diathermy.

(c) Wooden tables with drop top and bottom and boards to be used as arm rests. These should have auto-condensation pads built into the tops. There should be a table of this type for each compartment in the physiotherapy unit.

4. *Continuous currents.* A combination apparatus giving galvanic, faradic, and sinusoidal currents should be had.

5. *Roentgenotherapy.* This should be handled in connection with the x-ray department and thus avoid duplication of equipment.

6. *Hydrotherapy.* The selection of hydrotherapy equipment can be left to the judgment of each individual physiotherapist. The whirlpool bath, the needle shower, the sitz bath and the full bath, all have a definite field.

7. *Miscellaneous.* Massage can be performed on the tables already described. Corrective exercises may demand special equipment for special cases, particularly in orthopedic work.

Personnel.

The physiotherapy department should be a definite and separate department in the hospital and should be in charge of a competent head whose duty it should be to supervise and carefully check the work of the physiotherapy aids. The head of the department should be available for consultation at all times and should give

*Read at the annual meeting of the Michigan Hospital Association, December, 1925.

advice as to the type of treatment, time of treatment, and amount of treatment required, when called upon to do so. Physiotherapy aids, both male and female, may be obtained through the several hospitals who train them. One or two nurses should be assigned to each aid to facilitate routine work.

The problem of treatment we divide into two distinct phases, first, that of treatment in the out-patient department, which handles all of the outpatient cases referred to the hospital, as well as the clinic work. These are taken care of in the department set aside for this purpose, which should contain a small office for the physiotherapy aid, in which the history is taken and the case notes are typewritten and filed; several compartments containing the various forms of treatment apparatus and small separate dressing rooms for the patients. Of course space and amount of money available will regulate this phase of it.

Use of Portable Equipment

The other phase is the in-patient work and it is here that the portable equipment shows its value, and most of the equipment should be of the type that can be easily moved to the wards and the private rooms for the treatment of those patients who cannot come to the physiotherapy department for treatment.

We have found it convenient to have all of our physiotherapy requests made on a definite chart, herewith presented. This comprises a short history of the case and the type of treatment requested. The chart is one on which

the kind and number of treatments given can be easily marked. The progress of the case can be kept on this same chart. It is interesting and instructive to cross index the various types of cases seen by diseases and also by modality used. This is important for the purpose of reference and can be done on simple blank cards properly indexed.

The variety of types of cases for which treatment is requested surprises the uninitiated, and care should be taken that the physiotherapy department does not act as a dumping ground for patients sent in without diagnosis and without a definite scheme of treatment; in other words, the chronic case, which the doctor wishes to get rid of. Only cases in which experience has proved that physiotherapy is of value should be accepted for treatment, and then only as an aid to the proper medical and surgical procedures, individual in each case.

For convenience in description I have divided the types of cases handled into medical and surgical.

1. Medical cases.

It is a rather difficult matter to determine where the medical case leaves off and the surgical case begins, but in the following types results have been obtained.

(a) *Simple hypertension* may be treated by means of auto-condensation. Of course, results obtained are not permanent, but palliative treatment helps at times.

(b) *Phlebitis*. Radiant light and double cuff diathermy have given marked relief from pain and some improvement in this stubborn condition.

(c) *Anemia* has shown improvement with the use

FORM PT 1 IM 3-3-25

THE GRACE HOSPITAL

Physiotherapy Department

Name _____ Room _____ Ward _____ Hospital No. _____

Address _____

Diagnosis _____ Age _____

Present Condition _____

Type of Treatment Requested _____

Consultation _____ Desired _____

Part of Body to be Treated _____

Physiotherapy Ordered _____ Given _____

Month

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Massage																															
Ultra Violet Ray																															
Diathermy																															
Thermotherapy																															
Electrotherapy																															

Chart used in the physiotherapy department which comprises a short history of the case, type of treatment requested and kind and number of treatments given.

of heliotherapy and tonic massages in many cases.

(d) *Functional cardiac disturbances* have reacted very favorably to graded exercises and massage.

(e) *Visceroptosis* and a resulting chronic constipation respond fairly well to exercise and active massage of the abdomen.

(f) *Head colds* can be very well attacked by the use of indirect diathermy.

(g) *Bronchitis* can be treated and relief from pain and coughing can be obtained. The only contra-indication is where expectoration is very profuse.

(h) *Pneumonia*. Our results in pneumonia by treatment with diathermy have been excellent. Stuart states that, "the average death rate in treated cases is less than 14 per cent and that no case had been lost, which had been treated before the third day."

(i) *Rickets and asthenic diseases*.

The work of Hess, Unger and others has shown that in rickets, tetany, and asthenic diseases; in fact in all types in which there is a decided lack of calcium and phosphorous in the blood stream, ultra violet radiation acts as a specific, and thus the field of pediatrics has received an enormous aid through physiotherapeutic contribution.

(2) *Surgical cases*.

Nerve injuries. In nerve injuries and paralysis, after the acute stage, radiant light, diathermy, massage, and sinusoidal currents are indicated, always remembering that the most important modality in the above types of cases is common sense. Neuritis may be treated by direct diathermy and heat. Granger of Boston, uses ionization with the galvanic current.

Osteomyelitis. Ultra violet ray used over the body, generally with the air-cooled lamp and with pressure treatment over the diseased areas by the Kromayer lamp, shows exceptional results. It brings about the quicker separation of a bony sequestrum and in the after-treatment following operation, shortens by many weary days the convalescence of the patient.

Bone tuberculosis. I cannot do better than quote Sir Henry Gauvain of the Royal Society of Medicine, who, in discussing the light treatment for surgical tuberculosis, stated that he considered light treatment a valuable accessory, and that in sinuses, suppurating and discharging glands, and bone tuberculosis, the results were far greater than he expected.

Arthritis. In the acute case, heat, light, massage and indirect diathermy give remarkable relief. In the sub-acute case through and through diathermy, massage and corrective exercises should be used. It must not be forgotten that all other medical indications for arthritis are to be met.

G. C. Arthritis. Radiant light may be used in the acute stage. In the sub-acute stage intensive through and through diathermy is required. In the chronic stage, diathermy, massage, active and passive motion, and galvanism.

Industrial injuries. The field of industrial surgery has been almost revolutionized by the results from the use of physiotherapeutic measures, countless hours of suffering being prevented, a much quicker restoration of the patient to normal and the resultant saving of much money to industry have been realized.

Fractures. Massage, heat, diathermy, and ultra violet ray are indicated. Many cases of delayed union have been brought to satisfactory conclusion by the general stimulation of body metabolism and the production of an increase of calcium and phosphorous in the blood stream.

Dermatological cases.

Alopecia areata, acne, angiomas, burns, carbuncles, eczema, lupus, psoriasis, and pruritis, as well as a large number of other types, have a very adequate treatment method in the ultra violet radiation, the use of x-ray, or a combination of the two.

Cancer. In the superficial epitheliomas, the use of surgical diathermy produces destruction without the danger of spreading. Lymphatics are perfectly blocked off and the cosmetic results leave little to be desired. Carcinoma of the mouth, tongue, uterus, cervix and breast can be handled surgically by the use of the endotherm, coagulating and cutting with the needle. Complete sealing of the lymphatics is brought about, there is little, or no bleeding, and the tumor mass is lifted en masse from the site of operation.

Infections and ulcers. I think I may say without fear of contradiction that there is no other agent so valuable in the treatment of infected abdominal wounds, carbuncles, furuncles, general wound infection, and ulcers, as the ultra violet energy, the ray having the power of sterilizing the wound and causing epithelialization.

G. C. Infection, of the cervix, prostate, and epididymis have been rapidly cleared by proper diathermy treatment.

Orthopedic conditions. Practically the entire range of orthopedic surgery in its pre-treatment and after-treatment offers a fine field for physiotherapeutic measures. To go into detail would require entirely too much time and space.

Cosmetic deformities. Nevi, scars, keloid, warts, and moles, superfluous hair, all can be removed rapidly and easily by electrical measures. The results far surpass those obtained by the use of the knife.

Value of Physiotherapy?

In view of the fact that there is an ever-increasing demand by the public for active therapeutic consideration of ailments, and in view of the fact that physiotherapy has proved itself a valued aid to our present system of therapeutics, can we, conscientiously refrain from using these methods? Furthermore, the use of the electrical current, mechanical measures, and other physiotherapeutic measures, when scientifically applied, give an addition to the armamentarium of the physician that is extremely valuable, provided that too much is not asked of inanimate apparatus. It should be used as a medicine, rather than as a cure-all, but with a diagnosis made and physiotherapy indicated, surprising results can be obtained and the hospital can render a signal service by giving its staff an adequate department, properly equipped and properly managed.

DO YOUR LAMPS SERVE THEIR TERM?

Standard mazda lamps are made to give an average of a thousand hours of good lighting service. Few people know whether or not they do this, because there are many cases where it is almost impossible to check the life of a lamp. This is not true, however, in service departments where lights are burned night and day or a certain number of hours each day. It is in such places that the engineer of a San Francisco hospital tests the life of his bulbs. He marks the date on each bulb as he puts it in and makes note of the number of hours the burned out ones have served. This system has, in several instances, made it possible for him to get replacements on lamps that have not served their term of usefulness.

A SHORT HISTORY OF HOSPITALS: PART II*

By Virginia B. Miller,
Chicago

THERE is a flavor of romance clinging to the names of a great many modern hospitals. It has been the custom for centuries to choose a name for a hospital from the roll of famous hospitals or nursing orders of the past, especially the medieval past. A glance, therefore, into the history of those names will bring to light some of the romance in our modern institutions we are apt to overlook.

Hotel Dieu is one of the commonest of these names. The name, of course, came from France and was brought to America by French settlers. In France nearly every good-sized town has its Hôtel Dieu, which was originally an almshouse for the aged, the poor and the sick of all classes, but which, in medieval times, became a hospital in the modern meaning of the word.

The first Hôtel Dieu was founded, it is thought, in 660 A.D., by St. Landry, Bishop of Paris, in his palace, and in connection with the nunnery and chapel of St. Christopher. St. Landry sold some of the treasures of the church to pay for the upkeep of the hospital, and the sisters of the convent, who had dedicated their lives to embroidering altar cloths for the Cathedral of Notre Dame, nursed in the new hospital during their spare time.¹

About the year 1200 the hospital was moved from the gloomy old palace of the bishops of Paris to a new building and was called the Hôtel Dieu. A few years later the hospital was presented with several houses in the vicinity of the new building. Since there were no street numbers but only signs above the doors at that time, the hospital records thereafter referred to the buildings as "the houses with the image of St. Louis, with the sign of the golden lion of Flanders, with the images of the three monkeys, with the image of the iron lion, or with the cross of gold."²

The Hôtel Dieu of that time was run by the canons of Notre Dame, who obtained the revenue for the hospital "from all classes of society—nobles of the court, wealthy burghers, the beggars on the street," and from rural lands, church treasures and royal grants.³

The canons would send nurses out to search the streets and bring in any sick person they could find, whether Jew, Mohammedan, or Christian, rich or poor, soldier or citizen. If the patient were a Christian, as soon as he was brought in he heard mass for the peace of his mind. During his stay at the hospital he was asked to pray for his benefactors, the only pay for his care. While he was ill he was often visited by royalty, for Margaret of Navarre, the poetess, and the gentle St. Louis the Ninth, and

many others visited at the hospitals.⁴ Saints' days were the best days for visiting, since the nurses then decorated the wards and beds with garlands of flowers.

The nurses were the gentle Sisters of St. Augustine, who took the three vows of the Catholic Orders and cut themselves off completely from the outside world. Rules and routine that covered every hour of the day were made out for them by the Bishop of Paris. They ate their meals at long yellow tables, a step lower than the table of the Prioress, while one of their number read aloud from some religious work.

Each sister had her own work; one preserved the jellies and fruits, another made the bandages from old linen, another handled the drugs, another sold the belongings of the patients who died, several stayed in the wards, and a certain number did the laundry work in the Seine every six weeks, even in the mid-winter when they had to



The Hospital of Santa Maria degli Innocenti, Florence, Italy, showing the medallions by della Robbia.

break the ice on the surface before they could wade in.⁵

Their hours were long, from four or five in the morning until late at night, because there was not revenue enough to support many nurses. Conditions became so hard for the nurses that quarrels between them and the cathedral chapter broke out in the sixteenth century, and the president of the Sovereign Court of Parliament took over the direction of the hospital. Complaints were made that the sisters meditated too much, that they would pace the wards with bowed heads and would not hear the requests of the patients.⁶

But in spite of all the complaints there is no doubt that the sisters had their patients' welfare at heart and never lacked courage. When there was a fire in the hospital, so severe that it caused the death or injury of forty attendants and sisters, the patients were moved into other wards without mishap and with such dispatch that their medicines were only delayed two hours.⁷

The overworked sisters also had poor equipment for their nursing. For example, single beds were not in

*Part I of this article appeared in the February issue of THE MODERN HOSPITAL.

general use until the nineteenth century, and the Hôtel Dieu was so crowded that there were sometimes as many as six patients in an ordinary double bed, three with their heads at one end, and three with their heads at the other. The high wooden beds were crowded together so that many were accessible only from the foot, and the heavy red serge bed curtains of the winter months were none too sanitary.⁹

Mismanagement Prevalent

In addition to the poor equipment there was no order or centralization in the management; each division of the hospital had its own kitchen, laundry, and supply rooms, and contagious cases were put in the same wards, often in the same beds, with non-contagious cases. Indeed we read of hydrophobia and lunacy, the "king's evil" (tuberculosis), and surgical cases all in the same ward. It is said that scabies spread like fire through Paris from the Hôtel Dieu because of the disorder and dirt, because the dishes were not carefully washed, and because the infected clothes of the dead were sold to the public.⁹

For all these things we must blame the administration and the prevailing ignorance of hygiene rather than the faithful *Socurs Augustines*. For about twelve hundred years there has been a succession of patient sisters who have worked nobly and tirelessly in the dark old wards of the Hôtel Dieu.

Another great hospital of early times and one that has probably given its name to many modern hospitals is that of St. John in Jerusalem. It was founded in 1099 when the triumphant first crusade entered Jerusalem. A building near the church of St. John was given by some rich merchants from Amalfi to a group of crusaders who wanted to establish and maintain a hospital in the Holy Land.¹⁰ The group became known as the Hospitallers of the Order of St. John, and their hospital, accommodating two thousand patients, became famous for its service to the sick of all nationalities and religions. Christians rescued from slavery under the Mohammedans, crusaders wounded in battle, Europeans destitute and far from home or stricken by tropical illness, Mohammedans and heathens, pilgrims and beggars all were treated with equal care and respect. Indeed it is said that the Hospitalers themselves ate only coarse black bread but gave their patients bread made from the purest meal.¹¹

Hospital Supported by Pilgrims

Gifts to support the hospital came from pilgrims who had made their way painfully across Europe to the Holy Sepulchre, from princes who stayed at home, and from Christian countries all over Europe, until the order held valuable lands in many countries and could carry its work of charity beyond the Holy Land. It even undertook the military protection of its patients and convalescents during their homeward journey across Europe and founded branch hospitals in the Mediterranean ports where crusaders gathered.

But meanwhile the tide of battle was turning against the crusaders in the Holy Land until finally the city of Acre, their last stronghold, fell. The whole order of the Hospitallers of St. John was massacred except seven, who escaped by sea. They were given the island of Malta, and there, at Valetta, they built a hospital of great architectural beauty.¹²

Its walls were thick and strong and it was so large that there was room for many small wards and one large one, five hundred feet long. The few high windows left a monotonous expanse of wall for the patient to look at, so

that the walls of the great ward were hung with tapestries of delicate coloring. Each bed was covered with a net suspended like a bell so that the patient was not bothered by flies. The patient was fed such delicacies as pomegranates, plums, eggs, game, and soups made of many kinds of fowls, all served on silver plate.

Two "knights of integrity" watched the distribution of the food and also gave away outside the hospital alms, crutches, bandages, sheets, and covers, and made it their business to see that foundlings were given a home. One knight was in charge of the linen, another of the bread and wine; an *armorière* was in charge of the silver, a clerk of the expense accounts and wills, and another



The costume of physicians when visiting cases of contagious diseases.

knight lectured to the staff on anatomy and diseases.¹³ Their uniform was a black robe with a white linen eight-pointed cross (in commemoration of the eight beatitudes) appliquéd on the front, and a black cloak with the white cross of Jerusalem on the side; a cross intersected making five crosses in memory of the Savior's five wounds.¹⁴ The women who were admitted to the order wore a red robe and a fur trimmed black mantle with the same crosses. Like the Red Cross workers of today both the men and the women of the order worked, if necessary, on the field of battle.¹⁵

The head of all the nurses at the hospital, both men and women, was a knight who accompanied the physicians on their rounds, and in order to keep the wards quiet, visited them all many times night and day. There were several small wards so that there could be a separate ward for each different complaint; one for hemorrhage, one for fevers, one for the mentally ill and one for the dying.¹⁶

All these details show that there was order and centralization in the management, and intelligence and kindness displayed in the care of the sick. But, like the Hôtel Dieu, this hospital also deteriorated. The reason some give is that the Hospitallers were less interested in their works of mercy than in their ceaseless war against unbelievers. The result was that in 1786 John Howard, during one of his journeys through Europe for the pur-

pose of exposing the unbelievably vile and inhuman condition of prisons and hospitals, found conditions here no better than in the other hospitals and wrote a most depressing account of the filth and gloom and neglect in the old hospital at Malta.

Although the most famous hospital of the order of St. John fell into decline and disuse, the order has had an influence in the hospital work from the time of the crusades until recently. In England the Hospitallers directed the institution of St. Cross for a short while, and their rival order, the Templars, were given, by King Stephen, the direction of a Yorkshire manor. There pilgrims were to be received, and every evening at dusk the Master was to sound a horn across the moors so that the late pilgrims would not lose their way."

Order of St. John in England

So far as we know the first hospital in England, named St. John, was built in 1084 by Lanfranc, the old Italian whom William the Conqueror made his Archbishop of Canterbury. He built it in the side of the city walls in York, similar to those he had known in Italy. Other hospitals named St. John followed until this became one of the commonest names in England in the Middle Ages, and many interesting bits of information about these hospitals have been recorded. It is said that from the hospital of St. John in Sandwich Village, Kent, one brother rode on an ass through the shire begging for his hospital, and that he would get ten shillings a year in this way, in addition to his expenses. Another brother would go to church every Sunday with a pewter dish and beg money to buy meat for the patients' Sunday dinner." At the hospital of St. John at Sherborne it was the custom on Midsummer Eve, in memory of St. John, to hang a garland of flowers on the door to be watched by the almsmen till dawn."

While many of these hospitals were dedicated to St. John, the Evangelist, St. John the Baptist was a more common patron. In the Savoy Hospital, London, there was a chapel of St. John the Baptist, which was famous for the secret marriages performed there. A notice appeared in 1754 in the *Public Advertisers* stating that for two hundred years respectable and legal marriages had been recorded in the registers of this chapel, that the charge for marrying was merely one guinea, and that there were five private entrances to the chapel by land and two by water.

The Order of St. John was revived in Germany in 1852 for the purpose of establishing rural hospitals and providing nurses for them. But the most impressive reminder now of the old Order of the Hospitallers of St. John is the great number of hospitals named St. John."

Order of St. Mary Magdalene

A name which is often used for hospitals and one which in the beginning was closely associated with the order of St. John is the name of St. Mary. In the Holy Land the sisters of the Order of St. Mary Magdalene, the women's branch of the Hospitallers, distinguished by their red habit embroidered with the cross of St. John, worked among the wounded on the field of battle and among the sick at the hospitals of St. Mary throughout Palestine. Like the Red Cross nurses of today, they were famous for their work in time of flood, famine, epidemic, or war, both in the field and in the hospitals.

In Florence there was the Santa Maria Nuova hospital, a building of great beauty. It was founded by Portinari, the father of Dante's Beatrice, to humor one of his old servants, Mona Tessa, who was devoted to the care of the

sick. So that she could nurse several patients at a time, he bought and gave her a house, probably very near the spot where Dante, half hidden, used to wait for hours at a time for a glimpse of the lovely Beatrice.

The house proving still too small, a larger and better building was provided. The new hospital was so efficiently run, the management and nursing so good, and the wards so clean that the Pope and the English king asked for copies of its regulations for use in hospitals throughout Christendom." The nursing was done by the sisters of Santa Maria Nuova, who entered the hospital from their adjoining convent by way of an underground corridor.

These sisters, in their long woolen robes and veils, still do the nursing in most of the Florentine hospitals."

A famous Florentine hospital where nursing has been carried on for centuries and one which is still doing its very useful work is the Santa Maria degli Innocenti for foundlings." According to the custom of the times, lost or deserted children were the property of anyone who happened to find them, and they were usually sold as slaves. This hospital was established for the purpose of protecting such foundlings. They were taken in and as tenderly watched over and as carefully fed by the sisters as any children in Florence. When a traveller, returning from Spain, told of seeing cows' milk used successfully there as a food for children, the sisters of Santa Maria procured some for their foundlings and discovered that they thrived on it.

At the age of seven the children were taken from the sisters and placed with private families to be brought up. Their adopted parents gave the girls their dowries or sent them to a convent and taught the boys a trade. The patrons who started this work were the guild of silk merchants, and the beautiful hospital they erected is noted for its bas-relief medallions by della Robbia."

Order of St. Mary at Siena

Another well known Italian hospital of St. Mary was the wealthy Santa Maria della Scala in Siena. It was founded in the ninth century by a humble Christian named Soro, who had obtained gifts enough for his work among the ailing and needy to build a hospital. The marble with which it was built was taken from an old Roman temple to the goddess Minerva which had stood on that same spot. The hospital walls were adorned with great paintings illustrating the work being done in this institution.

As in the Santa Maria degli Innocenti, foundlings were received and nursed and carefully brought up, but the Santa Maria della Scala also raised money for their dowries and married them well, as the paintings testified. In addition, the latter hospital distributed alms to the poor, nursed the sick, and gave shelter to strangers."

Another well known hospital named Saint Mary is the Old St. Mary of Bethlehem in London. "Bethlehem, or, as the name was softened in the English speech of the people, Bedlam, was founded about the middle of the thirteenth century. Originally it was a general hospital for the care of the sick of all kinds though in later times it became, as its name has come to signify in modern English, a place exclusively for the care of mental cases."

Long Record of Bedlam

Its record of nursing has been unbroken because of the assistance given it by several important personages. The Mayor of London aided it when, at the dissolution of the monasteries, the property owned by religious bodies was confiscated. Henry the Eighth, when petitioned by the people, condescended to allow the city to continue to run it," and Queen Elizabeth sent out a plea for money for

the hospital with these words of explanation: "Sume be straught from there wyttes. Thuse be kepte and mayntend in the Hospital of our Ladye of Beddelem untyle God caule them to his marcy or to ther wyttes agayne."¹⁰⁰

Her plea must have been successful, for the hospital prospered and in 1675 was rebuilt at a cost of seventeen thousand pounds. The new building was an exact copy of the Tuilleries. When Louis XIV heard this, he was so angry that his palace had been used as a design for a mere hospital that he caused his architects to make a copy of the palace of St. James, which he used for offices "of a very inferior nature."¹⁰¹

The hospital of St. Mary of Bedlam was run with more care than many of its contemporaries. In its old book of rules and regulations there are a few orders that sound very odd today. If any lunatic escaped, the servant who, through neglect, was responsible for the escape, was required to pay for the expense of catching the patient again. Each patient had to appear, after a few months' care, before the committee in charge; if he was cured he was set free, but if he was pronounced incurable he was sent to his relatives. If an incurable was adjudged dangerous, he might be taken into the hospital again when a vacancy occurred among the limited number of incurables who were allowed to remain. No patient was allowed to have any scissors or sharp instruments, nor was he given tea, wine, strong beer, or sugar.¹⁰² The present St. Mary of Bedlam is in a building erected in 1812 and receives only curable and acute cases among those of the better educated classes.

1. Nutting and Dock, *op. cit.* p. 292 ff.
2. Clay, *op. cit.* p. 253.
3. U. S. Medical Bulletin, *Hôtel Dieu of Paris*, 1918, 12, p. 603.
4. *Catholic Encyclopedia*, vol. VII, p. 486.
5. Nutting and Dock, *op. cit.* p. 292 ff.
6. *Ibid.* p. 318.
7. *Ibid.* p. 309 ff.
8. *Ibid.* p. 305.
9. *Ibid.* p. 329 ff.
10. *Catholic Encyclopedia*, vol. VII, p. 483.
11. Nutting and Dock, *op. cit.* p. 179.
12. *Ibid.* p. 195 ff.
13. *Ibid.* p. 195 ff.
14. *Ibid.* p. 181.
15. *Encyclopedia Americana*, vol. XIV, p. 428.
16. Nutting and Dock, *op. cit.* p. 206 ff.
17. Clay, *op. cit.* p. 206.
18. *Ibid.* p. 185.
19. *Ibid.* p. 250.
20. Burdett, *op. cit.* p. 517.
21. Clay *op. cit.* p. 246.
22. Nutting and Dock, *op. cit.* p. 241 ff.
23. *Ibid.* p. 278.
24. *Ibid.* p. 242 ff.
25. *Ibid.* p. 242 ff.
26. *Ibid.* p. 246 ff.
27. Walsh, *Popes and Science*, p. 248.
28. Clay, p. 34.
29. *Ibid.* p. 238.
30. *Ibid.* p. 34.
31. Houghson, D., *History of London from an Actual Perambulation*, 1805, vol. III, p. 31.
32. *Ibid.*

WHAT HOSPITAL SERVICE MEANS*

Hospital guests are sick. Many patients employ private physicians who naturally study the service afforded by the institution rather critically. Relatives and friends of sick folks are constantly in attendance. They fix one eye lovingly on the patient and the other threateningly on the organization and its general management. The general public assumes a questioning attitude toward all hospitals.

One of the queer kinks in human nature spells trouble for many who find themselves in hospital wards. A fair proportion of invalids are people of small means. Some are absolutely without funds. Most of us unconsciously assume the undemocratic attitude that rich people have a

constitutional right to snobbery and that poor folks are in duty bound to practice humility. The fact is that all men are born free and equal in the matter of virtues and vices. Human nature, as a mass, runs true to form, rich and poor alike. Plenty of poor people are snobs. A considerable proportion of rich folks wear the cloak of humility. Hospital employees especially are apt to overlook these truths. Often they restrain their resentment with difficulty, when a patient who makes an unreasonable demand happens to be a public charge.

Hotels aim to please. If the guest asserts that a room is cold, the clerk decides that it is cold, even though the room thermometer may register 90° F. If a steak is alleged to be overdone and not rare as ordered, the head waiter gazes at the half cooked morsel of meat and calmly announces that the guest is unquestionably right. An individual, who perhaps entered the dining room but five minutes before, angrily demands to see the proprietor. Upon the appearance of this dignitary, the disgruntled one complains bitterly that he has been kept waiting three-quarters of an hour without attention. A hungry person is apt to lose all sense of time. The proprietor knows this. He condoles with the impatient guest and agrees that the complaint is well founded and shall have immediate attention. Similar examples might be cited without number.

Teach Employees Courtesy

A policy such as the one outlined might be defined by unthinking persons as servility, rather than service. In reality it is service reduced to terms of politeness and consideration. Its effect upon a guest is usually swift and sure. Insolence never yet cured insolence. Unreasonableness is not an antidote for unreasonableness. Hotels have accumulated fortunes by astutely commercializing the biblical injunction, "A soft answer turneth away wrath."

Hospitals have not yet learned this lesson. Institutions for the sick also aim to please, but their task is infinitely more difficult than the similar one set for institutions catering to the well. Hospital superintendents have been remiss in not teaching employees politeness first, last and all the time. The latter are prone to accept the unreasonable demands of patients as personal affronts.

Daily contact makes it easy to forget that a body diseased often means a mind disordered. Many are on the verge of a nervous breakdown. Some are actually in danger and know that death is within the range of probability. Pain and distress are usually accompanying features. Surely such patients find small comfort in the coldness and indifference often encountered in places that claim to be organized for the purpose of promoting health and consequently happiness. These remarks apply with double force to an infant or child snatched from the arms of a loving mother and placed in a hospital ward with not a familiar face in sight. Hospital attendants are seldom positively cruel. More often they exhibit this tendency in a negative sense, expressed by inattention.

Physicians and nurses particularly should adopt the hotel plan of service, and incidentally comprehend the fact that hospitals were organized primarily for the treatment of sick persons, not to provide places for the staff. Hospital attendants should maintain an inexhaustible supply of kindness, consideration and forbearance, especially the latter, ready for instant use. An aptitude for debate and a natural or cultivated taste for recrimination have no place in the armamentarium of a doctor or nurse. A mind small enough to interpret as a personal affront the peevish or unreasonable complaint of a sick individual means that its possessor is totally unfitted to practice the healing art or care for those distressed in mind and body.

*From the bulletin "Service" issued for the benefit of the employees of the Buffalo City Hospital by Dr. Walter S. Goodale, superintendent of the hospital.

WHAT OUR HOUSE ORGAN ACCOMPLISHES FOR US

By Frank E. Brooke, Superintendent, Harrisburg Hospital,
Harrisburg, Pa.

THE *House News* of the Harrisburg Hospital, Harrisburg, Pa., began its existence a little less than a year and a half ago as a means of acquainting the patients of the hospital with their neighbors within this little community which they had temporarily joined. In the early issues, the "News" was made up of personals of visitors, guests, personnel, of bits of poetry or humor that might entertain, and extracts from answers to questionnaires sent to discharged patients, asking for their impressions of the intern and nursing service, dietary, housekeeping, and for any other constructive suggestions they might wish to make. Copies were distributed to all patients and personnel, and sent to members of the board of managers, advisory board, and some other friends.

We began with the intention of keeping the production of this tabloid newspaper within the hospital. Not only was the news to be gathered and written in the institution, but it was to be made up in the superintendent's office. For every issue mimeograph stencils are cut, and a paper consisting of from three to five mimeographed pages, eight and one-half by thirteen inches in size has been published. The cost of material for an entire issue of from three to five hundred copies has not exceeded five dollars. Many times suggestions have been made that the copy be sent to a printer, but the high cost of printing has been a factor in our decision to continue mimeographing it. We also think that the little house organ is more intimate in style than it

could ever be in cold type. And it is the writer's opinion that we all regard it more our own because we do all of it.

The thought of those who have suggested the printing of the paper has been to increase its circulation upon the theory that the influence of a paper is measured by its circulation. Later on in this article it will be explained that without aiming at publicity we are now publishing it in better form than by circularizing the public with a monthly bulletin.

Like a great many other young journals, the "News" excited no small amount of discussion and criticism. Perhaps the widest range of opinions was provoked by the selections of poetry and of humor that were included.

In order to popularize the little paper its make-up was left to one of the hospital personnel. Much discrimination was required in the selection of jokes, which proved to be in itself a serious business. From one of the earlier issues we clipped the following from a columnist:

"A contributor has protested that there is no parking place for pedestrians. He forgets our commodious cemeteries."

An esteemed supporter of the hospital told us that it would never do to use such items again. The word

"cemetery" should never be used in a hospital publication of any description.

Standardization in America does not seem to have been applied to this field. The assistance of a number of experienced experts was made use of with the result that the department of humor, if we may so term it, has been entirely eliminated from our make-up.

As our original hope, still clung to, was to furnish diversion to patients the cross-word puzzle fad was accepted as a medium for promoting diversion. This feature has likewise been discontinued with the passing of the fad.

Every patient discharged from the hospital receives a letter three days after departure enclosing a blank for reply asking the patient to state (1) whether the attention received from interns was satisfactory; (2) whether

the nursing service was adequate and satisfactory; (3) whether the food was satisfactory; (4) whether the hospital was clean; (5) whether the patient can make any suggestions as to improvements that may be made in any way. More than one-half of our patients answer these questionnaires in full and nearly all of them append a note giving permission to publish their replies in the *House News*. The earlier replies stated merely obvious things and for a while read very much alike. A distinct improvement in style was noticed after we began to ask permission for their publication in our *House News*, and we have now many more than can be used in each issue. It has been our policy to

insert in the paper every criticism that does not seem captious, even though it may not appear constructive. In this way we feel that the patients appreciate that we really want to make use of their suggestions. This department has never failed to interest and as the publication of favorable comments has been inevitable, the department has been of the greatest value to the hospital.

The selection of subjects for personal mention demands the exercise of considerable discretion. The privacy of our patients is respected while they are in the hospital and it has generally been thought best to mention their departure, when the prominence of the person or the nature of the case gave their names news value. Visitors who come to see the institution are mentioned, and in some cases their comments and suggestions are printed. Changes in personnel have always been noted and, from time to time, a list of the nurses who are assigned to the different departments is given. Last year when we opened up a new pavilion in which a new operating suite had been provided we listed the names of the patients who were the first to be operated upon in each department, and likewise the name of the first baby born in the new maternity department.



Acknowledgement of significant services by patrons to the patients is made through the pages of this paper. By this we do not mean the publications of those long lists that have by tradition been included in many, many annual reports of hospitals: "Lot of magazines, by James Wilson; Lot of medical books, by Dr. Clute." Such things are gladly received but are everyday occurrences. We record the names of the group that has come to entertain our patients during music week, or the name of the committee who presents and decorates Christmas trees for our wards in order to inform the patients to whom they are indebted for the service.

To acquaint patients, other than those who have occasion to use them, with a department of special merit in the hospital, we have printed in each issue for some months an article prepared by the head of a professional department, giving in brief and simple statement an idea of some department of special therapy, of diagnostic value, or giving an idea of the purpose of an intricate piece of apparatus and how it works. These articles have included the subjects of basal metabolism, electrotherapy, electrocardiography in order to acquaint patients with the functions of the various departments of the hospital.

Holiday Editions Prove Popular

Without departing from our mechanical methods we have found it possible to issue holiday editions in appropriate form. For our Christmas edition, 1925, we used a face page of special design which, though simple, created a demand for so many extra copies that our supply was soon exhausted.

Each employee of the hospital receives a copy of the paper, and the inquiries for additional copies show the thoroughness with which every issue is read. We have evidence that the printing of a letter from a patient who has commended a number of nurses, who are mentioned by initial only, is understood by every member of the training school. There seems to be no doubt that their morale is helped thereby. We believe that every nurse looks for an item of commendation which she may take to herself.

Promotes Cooperation of Personnel

During the past year the census of our enlarged hospital did not come up to our expectations, and our income for some months fell short of our expenditures. Heads of departments were called together and a plan of curtailment was adopted. The support of the personnel was enlisted for the new program. In the next issue a statement was published showing a saving of 10 per cent in expenditure, and crediting to each department its share of the saving. Every employee was by this means informed of what his department had done for the hospital. The result for each month has likewise been given in later issues and each employee knows that through the efforts in which each had a part the goal of economy set is each month being reached.

No article dealing with the development of a newspaper or periodical would be complete without a discussion of circulation. Ours from the first has been a select list including the patients, nurses, doctors, employees, board of managers, advisory board and woman's board, all of whom were already our friends.

While the publication was for inside distribution, we were not averse to publicity, and the fact that the Harrisburg newspapers are always ready to publish news of the hospitals, prompts us to send them a copy of each issue. Thus we have achieved a large circulation, measuring up, by economic gauge, to that of a real newspaper.

FINANCING HOSPITAL SERVICE

By Margaret J. Robinson, Superintendent, Montefiore Hospital, Pittsburgh

There are so many arguments in answering the question of how the constantly increasing cost of hospital service can be financed that it might be well to start on some basic hypothesis. This might be the fact that in order to eliminate the abuse of privilege and the leakage of waste, an institution should take in at least 65 per cent of its expenditures from the various outside sources.

There are not many ways of meeting this deficit. Happy is the hospital that has a large endowment that receives a definite pro-rata support for its free cases from the state, county or municipality. With this assistance, a sane economic management and a reasonable endowment the hospital becomes practically on "easy street" for its actual maintenance.

Community chests, federations of philanthropies, campaigns and tag days help to pay the deficits of other institutions and provide for growth. These have their benefits and disadvantages. The benefits, of course, come from the money produced to help support the institutions, and the community value lies in the fact that the community leaders are impelled to study and survey their public health conditions and control the drain from the public by unnecessary expenditures.

As for disadvantages, it may be distinctly said that any federated body composed of people outside the professional field of hospitalization which attempts to inject unwarranted supervision or interference in the professional affairs of the hospital or which presumes to restrict hospitals or to consider the professions of medicine and nursing simply as branches of social service, becomes, in many cases, more of a handicap than an asset to hospital development.

MODERN ISOLATION HOSPITAL REQUIREMENTS

How does the isolation hospital meet the ideas of the health officer, suppose he were asked to score such an institution? His card would probably seek the following information:

1. Is the isolation hospital conveniently near to large centers of population?
2. Has it sufficient accommodations for all cases of infectious diseases likely to demand its service?
3. Are all cases held during the quarantine period and not discharged until free from all possible contagion?
4. Has it an up-to-date and efficient staff and equipment for all needs?
5. Has the superintendent freedom of action to institute suitable systems?
6. Is there a representative consulting staff for emergency operations?
7. Are defects in patients taken care of during stay in the hospital?
8. Is there a good follow-up nursing system to the patients' homes?
9. Are cross infections low in the average?
10. Is there an efficient ambulance service to reach all communities?
11. Are the laboratory facilities sufficient for all diagnostic and clinical purposes?
12. Is there ample and sufficient intern and nursing services?

—Journal of the Medical Society of New Jersey.

OUT-PATIENT SERVICE

Conducted by MICHAEL M. DAVIS, Ph.D., Executive Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York
and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York, 15 W. 43rd Street, New York

ORGANIZING THE DENTAL CLINIC

By W. D. Tracy, D.D.S., Chief of the Dental Service, Presbyterian Hospital,
New York

A FEW years ago a new hospital opened its doors to the public. It had a long list of attending physicians and surgeons and all the equipment necessary to take care of patients. After ten days the hospital was obliged to close because the superintendent was a person unable to delegate a job. She had to make out the nurses' schedules; see to it that the wards were properly manned; give out all the linen; she even had to be in the operating room if an operation were under way. In fact, she found it necessary to do everything. In a way, the habits of the physician and the dentist are similar. The idea of sharing a portion of the responsibility for the diagnosis or treatment of a patient by either physician or dentist is developing only gradually. The word cooperation, so overworked in other fields, is just now becoming used by the physician and dentist.

Mouth Ills Specialist

On account of the mechanical nature of dental work and the historical precedent that mouth surgery was performed by the barber, it has, in the past, been difficult for the medical profession to think about the dentist as a specialist in the ills of the mouth. All the necessary medical and surgical work has been done by the medical man before he has sent his patient to a dentist to have the masticating efficiency restored, in case he thought that was necessary to the health of the patient. Frequently, the dentist has found it difficult, if not impossible, in such cases, to make satisfactory restorations by the time the patient has reached his hands, although if the dental phase of the case had been studied in the earlier stages, clearing up the dental and oral disease would, no doubt, have been helpful in bringing about an improved physical condition. In addition to this, teeth which were neglected and, as a result were lost, might have been saved for long use and comfort.

Even in hospitals that may boast of having had a dental clinic for as long as twenty years, the medical men and the dentists have gone along year after year unaware of the fact that the others were working under the same roof and that great benefit might accrue to the patient, as well as to the dentists and the physicians, if they would work together instead of independently.

Reports received from all over the country indicate that the dental clinic in the hospital has progressed chiefly within the last ten years, with the greatest advance during the last five. Where the dental clinic is

ranked as a department and the attending dentists and oral surgeons are given a definite position on the hospital staff, the responsibility for the care of the patient, when he is referred from one department to another, is assured. The attending physicians in the other clinics will use that department when they see the necessity for a mouth examination, an x-ray diagnosis or some specific treatment. Where, however, the clinic exists merely because some interested dentist wanted to start it and because the superintendent of the hospital allowed it, just because other hospitals had dental clinics, there has been little progress.

In connection with dental surveys made in 1921 and in 1924 by Michael M. Davis of the Committee on Dispensary Development of New York, questionnaires were sent to hospitals of one hundred beds or more, outside New York City, to ascertain whether or not they had dental service, and, if so, what was its status. In the canvas of 1921, 282 questionnaires were sent out and 144 replies were received. Of these, eighty-nine reported dental service. Forty-six of the eighty-nine had departmental rank. In 1924, 385 questionnaires went out and 182 replies were received. These reported 135 hospitals with dental services, of which ninety-three had departmental rank. The increase in the number of clinics was 12 per cent in the three years, while the increase in the number of institutions that had raised their dental service to departmental rank was 18 per cent.

This rapid development of service has resulted in a grave lack of adequate and accepted standards in the policy, organization, and technique of dental service in hospitals. For this reason, a professional committee,¹ under the auspices of the Committee on Dispensary Development, studied the different phases of dental clinic policy and management. The experience of institutions throughout the country, as well as in New York, was analyzed and tentative standards, based on the conclusions reached as a result of this study, were formulated. These standards were published in full in the *Journal of the American Dental Association*² and are summarized as follows:

There are two principles that should underlie the establishment of dental services in clinics and hospitals;

¹ Michael M. Davis, Ph.D., chairman, John C. Gebhart, W. J. Gies, Ph.D., James Greenough, M.D., Ellison Hillyer, D.D.S., Thaddeus P. Hyatt, D.D.S., Waldo H. Mork, D.D.S., John L. Peters, D.D.S., W. D. Tracy, D.D.S., Herbert L. Wheeler, D.D.S., Clare Terwilliger, R.N., secretary, and four technical subcommittees.

² Tentative Standards for Dental Clinics, *The Journal of the American Dental Association*, November, 1925.

first, the medical or health need, and second, provision for professional supervision. The need divides into three parts, diagnosis, preventive dentistry and curative dentistry. Provision for supervision should insure permanency to the project, high quality of service and, in some institutions, facilities for teaching. The application of these principles constitutes a policy for conducting dental service.

Since hospitals, detached clinics, public schools, health centers, settlement houses, churches, relief and other types of organizations all offer dental service at times, it is evident that the principles must be modified according to the purpose for which each type of organization is in the field.

All medical or dental work has the double purpose of curing or alleviating disease and of preventing disease or promoting health. Prevention is so vital a factor in dentistry that one of the first points to be considered in any dental policy is prophylaxis or surface cleanings of the teeth.

Prophylaxis Protects Soft Tissues

Prophylaxis has been looked on as a method of keeping the teeth clean and white so that they would look and feel well. The really important element has been overlooked; namely, the protection of the soft tissues. By the removal of rough deposits from the teeth at the gum margin and under it, the soft tissues are saved from abrasions that may become ports of entry for infectious germs. The various forms of curative work should be undertaken as is required by the conditions suggested below. Modifications may be necessary on account of the size of the institution, the staff or the funds available, but the order stated should be adhered to in order to maintain as the ideal the ultimate health of every patient treated.

The hospital is for the care of the sick in bed; the hospital out-patient department and the detached clinic exist for the purpose of caring for the ambulatory sick. Their obligation to the patient in assuming responsibility for hospital care is both diagnostic and curative. Therefore, the types of work recommended in such institutions are listed in the order of their importance in clearing up systemic disease:

For adults: (1) Prophylaxis; (2) diagnosis, including roentgen-ray examination; (3) removal of unsavable teeth; (4) oral surgery; (5) treatment of pyorrhea; (6) reparative work, and (7) restorative work. For children: (1) Prophylaxis; (2) diagnosis, including roentgen-ray examination; (3) removal of unsavable teeth; (4) prophylactic fillings for the preservation of the first permanent molar or any other permanent teeth, and (5) silver-nitrate treatment for decaying deciduous teeth.

The reparative and the restorative work are important in that a proper chewing surface is necessary to digestion, but these types of service can be obtained at the office of a dentist or at a dental college after the hospital care is completed.

Must Choose Patients

A policy in regard to a choice of patients should also be adopted. If this is not done, a clinic is liable to become so crowded with patients applying for dental work only that physicians in other clinics of the out-patient department or detached clinic who need the cooperation of the dental service become discouraged and do not refer their patients. The choice should be made in the following order: First, emergency cases, as it is always understood in all clinics that emergency cases take precedence; second, patients who have come to the hospital, out-patient department or detached clinic, for conditions other than dental in which dental work will serve as an aid in therapeutic treatment of general medical and surgical conditions, or as a preventive measure; third, hospital personnel; fourth, children; if the institution has time, space, and personnel to do additional work, the clinic might receive for dental work children for all types of service and finally, adults.

In working out the place of the dental service in hospital or clinic organization, it was necessary to take into consideration the advances made by both the medical and the dental professions of late years. The interrelations of medicine and dentistry must determine, to a large ex-

tent, the type of organization best suited to carry out the needs in both branches.

The types of organization actually in practice show a range from the institution with a consultant on the staff, who is called when necessary, to a well-organized service with a definite policy that serves, as a matter of routine, every ward patient and all out-patient department clients referred from other clinics.

1. A definite policy should be adopted before instituting dental service, regardless of the size of the institution.

2. Dental service is regarded as an essential part of the work of a general hospital and should be organized as one of the professional departments of the hospital.

3. The dental service should be under the direction of a chief, who should rank with the chief or chiefs of other professional departments or services of the hospital, such as medicine or surgery.

4. Dental service should be represented on the general medical board of the hospital, in a manner conformable to that in which other major services of the hospital, such as medicine and surgery, are represented thereon. The general medical board is understood to be a body that should have supervision over the general professional policies and standards of the institution.

5. The dental policies and standards for the hospital should be under the professional control of the dental service, subject to final decision of the medical board.

6. The dental staffs of the hospital and its out-patient department should constitute one organization. The chief of the dental service should have direct supervision over the out-patient department.

7. Regular staff conferences of the dental service should be held for the discussion of ward and clinic cases, and dental staff members should participate in the general clinics or conferences.

8. The dental service should participate in the consultation facilities that are maintained among the various services of the institution. Professional responsibility for each patient should at any given time devolve on one service, those services to which the patient may be referred for consultation reporting to the service which has assumed responsibility.

9. The appointment of dental interns is desirable. They should be assigned definite duties in the hospital and the out-patient department under the supervision of the visiting staff of the dental service.

10. Surface cleanings, which are so important in maintaining a healthy condition in the mouth, should be done by oral hygienists working under the supervision of the dental staff.

11. A small institution that limits its dental work to a consultation service only should have the consultants attend at regular intervals instead of when called. It is desirable that such institutions should employ a hygienist to do surface cleanings, and to chart mouths. The appointment of a dental intern would also be advantageous, if financially practicable.

The question of oral surgery and its place in the hospital organization was taken up by a subcommittee.

Recommendation of the Committee

The committee recommended that: (1) Major oral surgery be under the supervision of the director of the general surgical service, except in a teaching institution, where it should be a separate service; (2) each institution have a separate dental department or service in which all problems of dental surgery are handled; (3) oral surgery be taught in both medical and dental colleges.

On account of the varying conditions in different institutions, the committee decided that no uniform size for a record could be determined. In order to have the information that is essential for the best treatment of the patient, the following recommendations were made:

1. The size of the record should be determined by the filing system in use in each institution.

2. The face of the record should contain:

(a) Whatever social service history is required by the institution.

(b) Case history, i.e.:

(1) Previous illness.

(2) Previous operations including hemophilia and reaction to anesthesia.

(3) Previous injuries.

(c) Examination record with chart.

"Just What a Ligature Should Be"

Fresh Material

ARMOUR'S Sterilized Surgical Catgut Ligatures, Plain, Chromic and Iodized, are made from sheep gut collected in our own abattoirs, where all animals are subject to State and Federal inspections before and after slaughtering.

Fresh material is selected, washed, and rinsed in running water until it is mechanically clean. The gut is then split lengthwise and the mesenteric portion discarded. Nothing but the smooth side is used. This insures a string that is free from weak spots and knots and that is absorbed uniformly after being imbedded in the tissues. The strands are then slimed, scraped and treated in such manner as to remove all but the clean sub-mucous lining. During this process, requiring several days, the material is kept at a low temperature (near freezing) to prevent fermentation and minimize bacterial growth.

Sterilization

While in a moist state and immediately before spinning and drying the strips of gut are sterilized in an air-tight chamber by means of sulphur fumes.

Hand Polished

After drying, all Ligatures are hand polished until perfectly smooth. They are then taken off the racks and gauged, sorted, and all traces of fat removed by proper solvents.

Chromicizing

Chromicizing of Ligatures is done in a way to make the strings stand up in the tissues 10, 20 or 30 days, as may be desired.

The Plain and Chromic Ligatures are cut into proper lengths, placed in sterile tubes, and completely freed from moisture by heat and covered with storing fluid. The Tubes are here sealed and sterilized at 320 degrees F.

Special Sterilization

A special sterilizer built of brick, steel and tile was designed by the Armour Construction Dept. Superheated steam, generated in a small chamber, is regulated by self registering mercury thermometers with charts, which are kept for reference.

After the final sterilization samples are taken from each batch and tested in the Bacteriological Laboratory by bacteriologists who are entirely independent of the manufacturing work.

The Armour Sterile Catgut Ligatures are supplied as follows:

Plain and Chromic, Regular (60 inch) lengths, sizes 000, 00, 0, 1, 2, 3 and 4.

Plain and Chromic, Emergency (20 inch) lengths, sizes 000, 00, 0, 1, 2, 3 and 4.

Iodized, Regular (60 inch) lengths, sizes 00, 0, 1, 2, 3 and 4.

An Armour Staff is working patiently and constantly in scientific research and in the commercial production of those surgical and pharmaceutical materials, whose only legitimate origin is the successfully conducted abattoir.



ARMOUR AND COMPANY
CHICAGO

3. The reverse side of the record should contain:

- (a) Record of operations with a small chart like the examination chart to indicate the surface of the tooth treated.
 - (b) Debit and credit columns.
4. The form used on the charts to indicate a tooth should be the circle divided in four segments to represent the four sides of the tooth with an inner concentric circle to represent the occlusal surface.
5. The standard dental symbols familiar to all dentists, anthropologists, anatomists, paleontologists and histologists should be adopted. The permanent teeth should be numbered 1 to 8 and the deciduous teeth should be lettered A to E, beginning in each case with the central incisor. The symbols (┐, ┌, └, ┘) should be used to indicate the position, whether it is upper or lower, right or left. Also that the symbol (X) be retained to indicate an extracted tooth.
6. Abbreviations, Greek letters, etc., should be abolished and operations performed be written out unless column headings are provided so that treatments can be checked.
7. The "key to the record" should be abolished.
8. Statistics of the number of patients, number of operations performed, visits of patients, etc., are poorly kept in many dental clinics. The terms used are often not comparable and the methods of collecting and tabulating the figures are frequently both laborious and inaccurate. It is, therefore, strongly recommended that a competent statistician devise a system for tabulating monthly and yearly reports.
- The following were the recommendations for dental clinic equipment in hospitals and out-patient departments:
1. The chairs should be easily adjustable and comfortable for both patient and operator and that they be constantly kept in good working order.
 2. A clinic doing work primarily for children should have a child's chair.
 3. A good lighting system should be provided.
 4. No elaborate or unnecessary fixtures should be used but only things that can be readily cleaned.
 5. Sterilization by boiling water should be done; also that an extra sterilizer be kept on hand for emergencies.
 6. Hot and cold water should be available in the clinic room.
 7. A washbasin with foot or knee controls, rather than hand faucets, should be used.
 8. An easily cleaned floor covering, preferably linoleum should be used. Tile floors are impracticable because of breakage of instruments which are dropped.
 9. A roentgen-ray machine should be available for the use of the dental clinic but preferably that there be a portable roentgen-ray unit for dental use only.
 10. Standard instruments suitable and sufficient for the operation of the clinic should be provided.
 11. Each clinic should have an attendant responsible for sterilization, cleanliness and any assistance the doctors may need.
 12. In case the clinic does its own laboratory work, a room with standard laboratory equipment should be provided apart from the operating room.
 13. A portable electric dental engine should be provided for clinics having more than one chair, instead of having wall electric engines for each unit, especially if only one chair is used at a time for fillings.
 14. The services of a pathologic laboratory should be available to the dental clinic.

Dental service in hospitals and clinics is still in its infancy as compared with the long established professional services of medicine and nursing. As the importance of dentistry is more and more recognized as a part of medical work and a means of restoring and maintaining health, a continuous and rapid increase of dental service may be expected throughout the hospitals of the country. Adequate organization and high technical standards will give this service a sound foundation in the hospital and the clinic and will hasten its development.

Prescott, in his "Conquest of Mexico," states that hospitals were established by the Aztecs in their principal cities for the care of the sick and the permanent refuge of disabled soldiers, and surgeons were placed over them, who, in the words of a cynical chronicler, were so far better than those in Europe that they did not protract the cure in order to increase the pay.

POLAR INSTITUTION SERVES AREA OF 60,000 SQUARE MILES

It is common for community hospitals to boast about the large territories they serve, but no hospital in America, regardless of its size, can vie in this respect with the hospital at Point Barrow Alaska, which serves an area of 60,000 square miles. It also has the distinction of being located farther north than any other hospital in the world.

When the hospital was built in 1920 materials for construction and its equipment had to be transported over 2,600 miles, the last 800 miles through storms and over-treacherous ice floes, with the aid of dog teams and sledges. It was built entirely by the natives under the direction of a white carpenter and his assistant.

It is interesting to learn that this northern outpost of modern science offers a comparatively diversified service, considering its size. It has a modernly equipped surgery, tuberculous, maternity and general wards and special isolation rooms. At present it has a capacity of seventy beds.

BOOKLET EXPLAINS DEPARTMENTS

The Post-Graduate Medical School and Hospital, New York, has published an interesting booklet explaining the provinces of its various departments and the responsibilities devolving upon department heads. The booklet is issued to the department heads, supervisors, interns, nurses and other personnel. It contains ninety pages, is bound loose-leaf with an attractive, flexible leatherette cover, five by eight inches. According to Louis C. Trimbel, superintendent of the hospital, the booklet has done much to eliminate interdepartmental friction.

GOVERNOR SMITH ADVOCATES PREVENTIVE MEDICINE

Governor Alfred E. Smith of New York, in his annual message to the state legislature stated:

"One of the great functions of government is the preservation of public health. Our state health department has established the slogan, 'Within certain natural limitations public health is purchasable.' No expenditure of public funds brings greater return to the state and its people than the money used for the promotion of public health. Prevention of disease is cheaper than its cure.

"I renew my recommendations of a year ago that careful consideration be given to the protection of the people of the state from unlicensed and unqualified persons practicing medicine. The cooperation of the medical profession is an essential factor in the protection of public health, as well as in the care of the sick. A large part of the modern public health movement consists in urging people to get the advice of their physicians before serious and perhaps incurable conditions have developed. Such effort comes to naught if unqualified persons are allowed to hold themselves out as physicians."

Thus another advocate of preventive medicine and a powerful enemy to the "cults" has gone on record.

The first privately endowed hospital of which there is any authentic record was founded in Florence by Falco Portinari, father of Dante's Beatrice. It was called the Santa Maria Annunziata. The second was founded in Milan by the Duke Francesco Sforza.

SINCERITY IN SELLING

By R. E. AMOSS

Secretary and Treasurer, Frank S. Betz Company, Hammond, Indiana



THE day of "black magic" salesmanship is fast disappearing. The high pressure artist, who put it all over you once and never expected to see you again, has killed himself.

The scientific operation of the hospital calls for business dealings with a firm whose selling methods are sincere.

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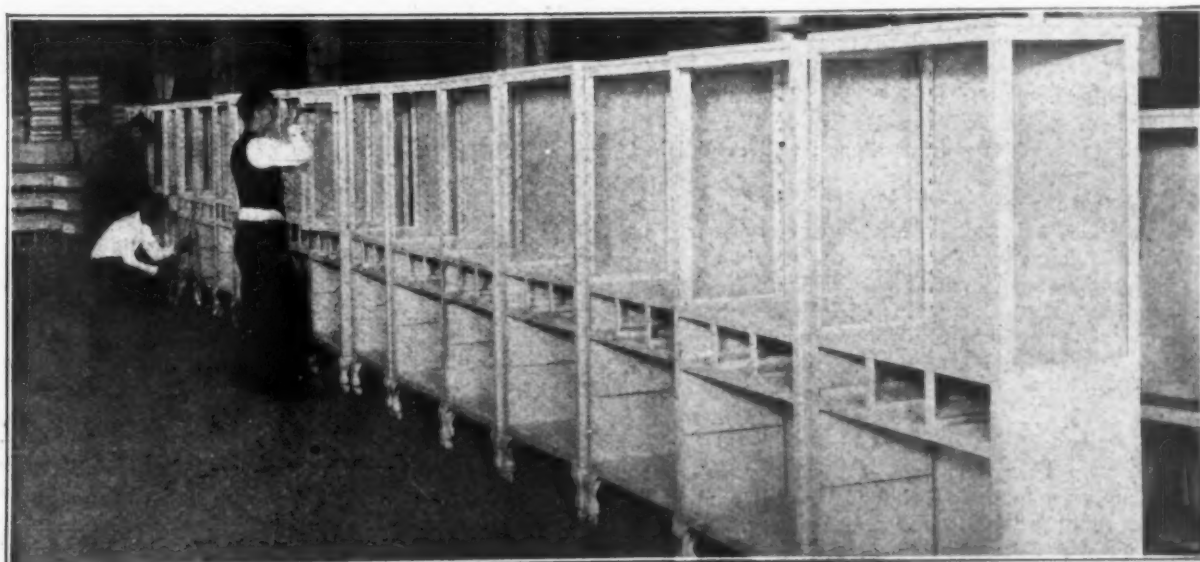
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WHY THE NURSE NEEDS TO STUDY PSYCHOLOGY

By Maude B. Muse, R.N., A.M., Instructor in Nursing Education, Columbia University,
New York

THE really successful nurse, like the successful doctor, preacher, lawyer and teacher is the one who, in addition to a knowledge of her profession, understands human nature. The ability to get along with people is a valuable asset in any profession, but it is absolutely essential to the nurse. The records of many training schools show that the occasional nurse never did learn to cooperate and her postgraduate experience is always a series of tragedies. Why was she graduated? Probably because she passed her examinations and was "good with her hands."

Even though the nurse is possessed of superior skill and able to put through any amount of hard work, if she is unable to get along with people she is always a failure as a nurse. Her own hospital frequently refuses to employ her as a special nurse, public health nursing is impossible, she does not fit into a doctor's office, and no institution or patient calls her the second time. Psychology early in training, and applied under supervision throughout the course, might have helped this unfortunate individual to make better social adjustments.

Contacts With All Classes

In many professions such as pedagogy, law and the ministry, the human contacts are relatively brief and limited in scope. The nurse, on the contrary, comes in contact with all classes of people, high and low, rich and poor, at all hours of the day and night, and from the cradle to the grave. Also, during illness, well established habit systems, tend to be demoralized, strong tendencies are thwarted, and numerous mental conflicts follow. Certainly all possible assistance in the detection, interpretation and redirection of such sick room reactions should be eagerly sought and utilized by the well trained nurse.

Granting that an understanding of human behavior is at least as vital to the successful nurse as to members of any other profession, the youth and inexperience of practically all pupil nurses intensifies their need of such a study. Many a young nurse is making her first contacts with illness. She may never have been ill herself or may not have been permitted to so much as enter the sick room except for a brief visit. With what is frequently a very limited experience, the average nurse cannot be expected to realize the demoralizing effects of even a slight illness, nor detect certain maladjustments that delay the patient's recovery.

The nurse frequently begins the study of psychology

with the impression that it is an exceedingly profound and mysteriously interesting subject. She may anticipate fascinating hours devoted to an analysis of her own thoughts, impulses and emotions; or hope to acquire an uncanny ability to "read minds" and character. Perhaps she dreams of suddenly gained will power, ability to concentrate and marvelously improved memory as advertised by several "schools of mnemonics." She is often much surprised and a little disappointed that she must begin her course in psychology with a study of the human nervous system, as a first step in an understanding of people and their reactions. She may lose interest during the necessary review of the neurological aspects unless she can be made to see the relationship between these and the subject matter of psychology. What, then, is the nature of the subject matter of psychology?

At the time when Socrates taught "Know Thyself" and Aristotle wrote his famous treatise on the "Psychology of the Soul," psychology was merely a chapter in the study of philosophy. In its subsequent development it passed through several stages. As someone has facetiously remarked,—"Psychology first lost its 'soul,' then it lost its 'mind,' next it lost 'consciousness,' but it still has behavior after a fashion." Psychology is today most frequently defined as the science of behavior. So defined, psychology becomes very comprehensive in scope. It seeks to discover what things human beings can do without learning and what they can learn to do. It considers how people are alike and how they differ. It attempts to classify their numerous activities in some orderly fashion. Because it is "a science," it seeks to evolve scientific laws which will help to predict and explain human behavior and to formulate certain principles which result in economical learning.

"Behavior" Includes Organism Activities

"Behavior" may be considered to include all the activities of the organism: Actions, speech, emotions, mental activities, glandular reactions or the absence of any of these when they should be present. It is, for instance, significant behavior which causes an individual to stand still on the railroad track at the sight of an oncoming express. In a similar fashion, absence of normal reactions in the sick may likewise create difficult situations. It is, of course, most important that the nurse be able to cope with acute delirium and sudden mania in her patients; but it is equally important that she should acquire



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skill in handling extreme apathy, mutism, tearless grief or the exaggerated state of indecision which is fairly common after severe illness.

When behavior is unsatisfactory a careful analysis of the total situation to which the individual is reacting should throw light upon the cause. Occasionally it is possible to change the situation and thus modify the behavior. Again, analysis of the situation in the light of certain native tendencies to response and the individual likenesses which appear as the result of social heritage, should enable the student of psychology to predict in a measure what response will tend to be made.

Predicting Human Response

The question at once arises as to what extent is it possible for a nurse to predict human response? Not at all in the sense that the chemist is able to predict the behavior of atoms and molecules or as the astronomer is able to foretell the movements of the stars. Psychology does not attempt to present mathematical formulae for the regulation of human behavior. It does reveal, however, that to any given situation normal human beings will react in a variety of ways. How they will react depends upon how some hundreds of generations of their species have reacted before them and how they themselves have previously reacted in similar situations, both of which may be ascertained. Therefore, because of the innate tendency of the human nervous system to form more or less permanent connections, known as stimulus response bonds, human behavior becomes relatively predictable. Granting this, a study of behavior demands a consideration of the neurological basis of the bond. What are the receiving organs which serve to put the organism in touch with its environment? What are the characteristics of the various organs of response? What is the nature of the bond formed? How do these bonds become woven into the complicated "reaction patterns" or habit systems that govern behavior? In other words, what is the physiological and neurological basis of behavior?

A nurse who has had good courses in physiology and neurology needs but to supplement and to organize her knowledge somewhat to serve as a basis for psychology. Knowledge of the structure of the sense organs and nervous system is, however, only a beginning. Psychology shows the rôle played by the sense organs in the behavior mechanism, and the effect of impaired sense organs, or ill-advised use of these receptors, upon behavior.

Make Use of the Eyes

Of primary consideration are those sense organs which are indispensable to the nurse—the eyes. Many nurses "have eyes and see not" while others are credited by patients with "eyes in the back of their heads." The student nurse should be made to see that the difference lies not in the organs themselves but in the connections established between them and the desired responses. Defective vision may often be corrected by the proper glasses; but this is no guarantee that the nurse will see the things which she, as a nurse, should see. Specific bonds must be formed before a nurse will be able to take in every pertinent detail of patient and environment at a glance. This is the reason why many silent witnesses of the patient's discomfort are not recognized as such by the nurse. Patients should not have to ask that blinds be drawn, the light shaded, the ice-cap or hot water bottle refilled, that lips be moistened, tongue cleansed, nor for many of the thousand and one things which mean so much to the sick.

The eyes of the patient also play an important part in the psychology of the sick room. They may be made invaluable allies to hasten recovery, particularly during convalescence. Through them the nurse may obtain a variety of desirable responses which directly affect the recovery of her patient. Florence Nightingale long ago recognized the importance of what she termed "slow variety" during convalescence. To use her own words, "A patient may just as much move his leg when it is fractured as to change his thoughts when no external help from variety is given him."

Innumerable ways of attaining 'slow variety' should occur to the nurse versed in psychology. Variety in the serving of meals as well as in the food served, variety in the site chosen for the wheel bed or wheel chair so as to afford a different view each day, growing flowers, one carefully chosen picture, changed occasionally, are a few of the most obvious methods that a nurse may employ to furnish "slow variety" for a patient who has been for some time acutely ill. On the other hand, a nurse who understands stimulus-response psychology will avoid subjecting the patient to a swift succession of stimuli early in convalescence. She will not place the patient who has been critically ill and is up for the first time, where he may watch the swift movement of a busy city street, or even on a veranda or in a sun parlor where many patients are collected and there is much passing to and fro.

Must Consider Sensory Stimuli

Reasons why the nurse must consider sensory stimuli in an attempt to modify the reactions of her patients so as to hasten recovery might be multiplied indefinitely, if time permitted, but two other types of mechanisms demand consideration—the response organs, muscles and glands, and the countless neurones composing the connecting mechanism.

The structure and functioning of the muscle effectors are familiar to the nurse, but she is not likely to realize, through the study of anatomy and physiology, the relationship between muscle tonus and strong emotions, for instance, or to recognize the possible effect of general hypo- or hypertonicity upon human conduct.

The second class of effectors, the glands, is likewise familiar to the nurse. She may, however, think of them only in their connection with the study of dietetics and metabolic disorders. The dynamic rôle played by the endocrines in regulating human reactions should not be overlooked. It is important, for example, both physiologically and psychologically, for a person to do something to "work off" the excess adrenin and glycogen which accompany a fit of anger rather than to sit and welter in his own secretions. The story of the ductless glands and internal secretions reads like a fairy tale. Indeed, in much of the recent literature dealing with internal secretions, there appears to be the same indiscriminate mingling of fact and fancy that characterizes the fairy-tale.

On the frontier, as it were, of this little explored glandular territory lies the thyroid. The most readily accessible gland, it has revealed more of its secrets than any of the other endocrine glands and, hence, may well be cited to illustrate the behavior aspects of gland functioning. Patients suffering from excess thyroxin are nervous, excitable, fearful and highly emotional. Echolalia, mania, and melancholia may appear in extreme cases. Any stimulus may become a new source of worry, anxiety and apprehension. For this reason, the nurse



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should recognize the psychological implication of a routine day of clock-like regularity for the exophthalmic goiter patient. The most successful treatment is, possibly, surgery at the hands of a skilled and experienced operator, but most surgeons frankly admit their dependence upon the type of nursing care which precedes and follows the operation. A nurse might well specialize in the study of the psychology of the exophthalmic goiter case.

A superficial survey might suggest the possibility of many disorders of the motor and glandular "reacting mechanisms" which are evidenced in behavior. In the larger per cent of the cases, however, the trouble is located not in the response organs, but in the third portion of the behavior mechanism, the great central adjuster, which the nurse knows as the central nervous system.

Behavior should be interpreted to include, besides words and deeds, certain responses that most of us tend to rank high in the scale of importance, namely, mental and emotional reactions. Tears, moans, restless movements, are no more significant forms of behavior than silent fear, motionless resignation, sullen revolt, hopeless acquiescence or demoralizing worry.

Psychology Aids in Detecting Symptoms

Knowledge of the external expression of the various emotions can not be taught in a lecture or book. It is to be gained only by close observation of many people. A course in psychology, however, early in training, should greatly assist the nurse in detecting symptoms of strong emotions among patients who often wear a mask, but tattle with their finger tips, restless feet, or bodily attitudes. As a rule patients should be safeguarded against strong emotions. Few people need to be told the effect of strong emotion upon appetite, digestion and elimination. However, more scientific evidence than that afforded by subjective experiences is available. X-rays of a cat while digesting a meal before and after being worried by a dog give conclusive proof of the effect of excitement upon digestion. That nurse labors more intelligently to secure a rapid convalescence for her patient who recognizes that one essential is to keep the strong emotions out of the sick room. Just as she will protect her patient from physical strain, so she will try to keep the patient free from emotional strain, including, as a rule, even pleasurable emotions which are too exciting.

The nurse versed in psychology will recognize why the organic states like anger, fear and excitement, set up in response to a certain stimulus may persist long after the reaction to the stimulus has disappeared, and predispose the individual to make a similar reaction to slight stimuli which would not ordinarily get that response. A certain hospital patient, for example, on "general care" was so upset if the attending surgeon and staff made rounds before she had shed her curl papers and donned her pink bed jackets that she would not get over it all day. Her exasperation and anger would fade but the nurses soon discovered that nothing could be done to please her for many hours, while on other days she was easily satisfied. The reaction of this patient should be recognized by the nurse as due to the blocking of a strong personality trend which could not fail to be annoying to the patient.

Human beings are born with numerous tendencies to react in certain ways and are likewise born to like some of these reactions and to dislike others, to be pleased by some and annoyed by others. The "original annoyers" are practically all to be met in the sick room. Physical pain, bad odors, bitter medicine, slimy things (like green

soap plasters), solitude, depression, unfamiliarity all are there. It will tax the ingenuity of the nurse to include many "native satisfiers."

The nursing implications are numerous. People when ill are, of necessity, thwarted frequently and in numerous ways. By original nature they tend to react to thwarting in a fashion that may delay recovery. No matter how "reasonable" they may try to be, thwarting tends to arouse a strong emotional response and thus interrupt the vegetative processes so necessary for convalescence. The nurse who is a student of psychology will realize that most people are natively endowed with a strong tendency to self-assertion. She will recall how thwarted self-assertion breeds sulkiness, peevishness, stubbornness. When such untoward reactions do appear in her patients, she will attempt to discover if the self-assertion of her patients has been unnecessarily thwarted and, if so, will assume some of the blame herself.

All organisms from the ameba to man find life a continuous series of conflicts. These conflicts are most numerous in youth because habitual adjustments have not yet been established. Severe illnesses create a situation so new and involve so much dependence upon others as to be comparable to childhood in the number of conflicts they present. The helplessness of the sick like the helplessness of childhood adds greatly to the normal conflicts which fall to the lot of all. Both situations may become prolific sources of maladjustments. Most nurses are at a loss to know how to proceed when they do recognize that an untoward adjustment is being made by a child or a patient under their care.

Some nurses argue that they are employed to help restore their patients to physical health and that the mental adjustments made by these patients are none of their concern. This attitude is, however, not in accord with the twentieth century ideal of preventive therapeutics and is already under criticism. Even slight maladjustments in nursery, schoolroom and sick room should not be ignored, tolerated, or ridiculed. The present nation-wide movement to educate parents and teachers in the psychology of character building must also be extended to include the nurse.

Methods of Dealing With Mental Conflict

There are in the main two general methods of dealing with the so-called mental conflicts which follow any thwarting of strong tendencies, native or acquired. The rational method is to face the issue fairly and squarely, and decide upon the best possible substitute activity. Adjustments on this level are, however, comparatively rare for two reasons; first, because most mental conflicts involve strong emotions which render logical reasoning difficult, and second, because comparatively few mental conflicts are recognized as such by the individual. The more common adjustment appears to be to evade the issue or deny that one exists. This latter method is responsible for an amazing variety of "retreats from reality" or "defense reactions," all of which are more or less blind attempts of the individual to secure satisfaction and avoid annoyance. Retreats from reality in childhood and in the sick room are almost inevitable; the problem is to prevent such reactions from becoming fixed as habits and character trends.

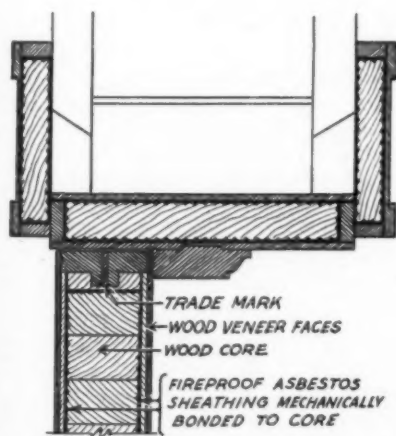
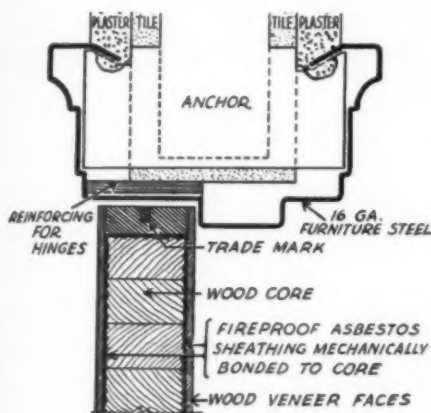
Nowhere does the law of cause and effect demand more careful consideration than in the nursing care of the mentally and emotionally unstable. Their peculiar constitution predisposes them to maladjustments, but this does not mean that maladjustments have to be made any more than that persons predisposed to tuberculosis must



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inevitably contract the disease. By securing a favorable environment and establishing correct habits, serious maladjustments may be prevented quite as well as tuberculosis.

Even a superficial observation of behavior reveals significant differences in the degree of emotional stability manifest in any annoying situation. Individuals differ no less in all other behavior characteristics. It is not enough, then, that the nurse should seek to discover ways in which individuals of the human race are alike. Psychological research has recently shifted from the earlier consideration of individual likenesses to the study of individual differences.

How Nurse May Aid Recovery

It is seldom possible for the nurse to know before hand the peculiarities of disposition and character of the series of patients who come under her care. In this respect the old-fashioned general practitioner has few equals today. He was personally acquainted with every member of the small rural or urban neighborhood in which he practiced; he knew all their peculiarities and idiosyncracies and those of their families and forbears. He had their implicit confidence. He knew just when it would be wise to conceal the serious nature of the case and when he could hope to arouse a fighting spirit which would help to win against disease. He knew which case could be influenced by subtle suggestions which would assist nature and the simple drugs he used to work a cure. The nurse cannot hope to understand her patients as thoroughly as did these fine old-fashioned doctors who are gradually making way for the modern specialist. She is seldom acquainted with her patients before their illness and frequently loses contact with them directly after recovery. She can, however, learn to recognize certain personality types; she can always keep in mind that no two people are alike in their reactions to environment and can take measures to adjust herself to their outstanding differences. She can also alter the environment of the sick room so as to secure the response which will best assist nature, and the physician or surgeon in restoring the patient to health.

Understanding Comes With Experience

This greatly to be coveted ability to understand and to influence people, to predict and alter human behavior, may sometimes be acquired through years of experience. It may, on the other hand, never be acquired at all. There can be no doubt that every effort should be made to build it up under guidance during training.

Before the nurse can do much to help her patients she must herself have made satisfactory adjustments to an absolutely novel environment. A knowledge of psychology should be of great assistance in helping her to fit into the new life of the hospital situation. Numerous maladjustments are revealed in the following complaints that will sound familiar to those closely associated with young nurses. "I worry so much about my patients that I cannot sleep nights." "I just can't take orders from that senior; why she is younger than I am." "I have not studied for years and I've quite forgotten how."

The nurse needs psychology also because she is a student. Few students anywhere are expected to cover so much and such a variety of strictly new subject matter in so short a time as is the student nurse in the preliminary period of her training, and this probably with a certain handicap of physical fatigue. It is true that a course in psychology does not always insure good teaching or guarantee economy in learning. A study of everything

ever written on the science of health and sanitation, for example, will not make a man any healthier unless he uses his knowledge to improve his habits of personal hygiene and the condition of his environment. Mastery of the facts and laws of psychology alone will not make for economy in learning. Improvement may be expected only when such knowledge is used to establish good habits of study and when opportunity is afforded for the exercise of these habits.

The path of experience ("trial and error" learning it is called in psychology) is a very old one and, of necessity, much traveled between birth and death. It is exceedingly wasteful of time and energy, many of its lessons being learned too late to be of much use to the individual. Modern students should be anxious to use the guide posts and sign-boards presented by psychology. But guide posts are quite useless unless correctly interpreted and accurately followed. Economy in learning presupposes a reading of the psychological signposts, but imposes the additional obligation of individual activity other than the mere reading and memorizing. Progress along the road of learning means expenditure of individual effort to overcome resistance; and all that psychology can hope to do is to point the right way and indicate the "steep grade" or "dangerous curve." It is a truism that there is no "royal road to learning."

Study Helps Nurse Herself

It appears evident, then, that a study of psychology should prove invaluable to the nurse herself. It is safe to predict that an adequate knowledge of the science plus a consistent practice of its teachings would assist greatly in the acquisition of the ability to cooperate with all sorts of people, subordinates, professional superiors, and colleagues; the ability to conserve time and energy so as to attain the highest degree of achievement; the formation of habits of economy in learning; the acquisition of motor skills and good technique in professional procedures.

The nurse needs psychology in dealing with her difficult patients. The problems which confront the nurse in handling sick people in such a fashion as to further their recovery and insure the minimum mental discomfort while the illness lasts; in managing anxious or interfering friends and relatives etc., are too numerous and too varied to be listed. The following will be recognized as common and fairly typical problem cases: the patient who stubbornly refuses to cooperate; the patient who repeatedly complicates recovery by infringement of restrictions, disobedience of orders, etc.; the officious patient who wishes to determine the character and direct the method of all treatment; the patient whose only association with the hospital is the death of some loved one; the patient who is tired of life; the hypochondriac; the drug addict; the delirious patient; the social derelict; the psychopathic personality, emotionally unstable, suffering from fears and obsessions, hysteria; the fractious child; the child with specific bad habits, etc. Obviously few of the cases listed can be handled satisfactorily by the young nurse without specific training. All that modern psychology has to offer to assist the young nurse in "nursing the mind" as well as the body should be recognized as an essential part of her equipment.

There is yet another important reason why the pupil nurse should study psychology. It is customary, in the better schools of nursing, to offer a course in mental nursing and psychiatry. It is certainly not reasonable to expect the nurse to get very much out of such a course when she has not had even the elements of psychology. As a basis for the study of psychiatry the course in psy-



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chology should stress from the start the possibility of the appearance in any normal individual of slight and temporary disorders differing in degree but not in kind from those classed as abnormal. There is no sharp line of demarcation between normal and abnormal, between sanity and insanity. A study of borderline and pathological cases helps materially in understanding the slight temporary maladjustments of normal individuals.

The pupil nurse of today should have a better basis for the study of psychology than the average college freshman, since its subject matter, human nature, is related to and dependent upon the other natural sciences of the training school curriculum. Anatomy and physiology treat of the structure and activities of the various cells, tissues, organs and "systems" of the body. Psychology considers the activities of the organism as a whole. Nurses are taught the reaction of body tissues and organs to vitamins and calories, to caustics and alkaloids, to endocrines and electrons. This is all necessary and good as far as it goes. What a mistake it would be to stop there and fail to consider the reaction of the organism as a whole.

The reasons why the pupil nurse should study psychology may be briefly summarized.

She needs psychology because she is a student making necessary adjustments to a new and strange environment.

She needs an impersonal understanding of people, especially of people when ill.

She needs elementary psychology as a basis for future study of mental nursing and psychiatry.

She needs psychology because she must, whatever may be the phase of nursing which she chooses upon graduation, become a teacher of health and preventive therapeutics.

A knowledge of psychology is an invaluable asset to the young nurse. Skill in giving treatments, good technique in doing dressings, keen observation of symptoms and knowledge about medications do not insure good nursing without an impersonal, sympathetic understanding of the problems involved in nursing the mind.

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Louis S. Olsen, A.B., health officer, Palo Alto.

Course Credit Instructor

Econ. 103 Care of Dependents . . . 4 units Lothrop

Pol. Sc. 119a Quantitative Measurements in Public Administration 2-4 units F. M. Fearing

P.H. 1 Health Department Administration 2 units Olsen

Psych. 51a

51b General Psychology . . . 5 units F. S. Fearing

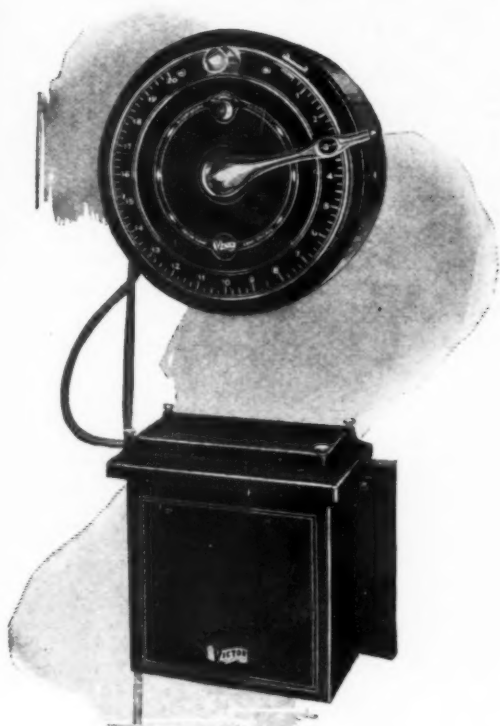
At these two universities living possibilities are attractive and not expensive. The association with teachers and other professional people from all over the country is always delightful. California is the favorite place for summer work, and professors from many universities are teaching during the summer session.

Further information regarding entrance requirements, tuition and expenses may be obtained by writing to the Registrar, Stanford University, Calif., the Dean of Summer Session, University of California, Berkeley, Calif., or Miss B. Hechtman, 815 Hillstreet Building, Los Angeles, Calif.

Helen R. Stewart has been made associate professor in the Yale School of Nursing, Yale University, New Haven, Conn., succeeding Amelia Grant. Miss Stewart was for four years director of the School of Public Health Nursing, University of Iowa, Iowa City.

Mary L. Wright, formerly superintendent of the visiting nurse association, Waterbury, Conn., has accepted a position in China under the National Council of the Protestant Episcopal Church in connection with St. Andrew's Hospital, Wusih, China.

Two Important Victor Developments



Victor Stabilized X-Ray Timer

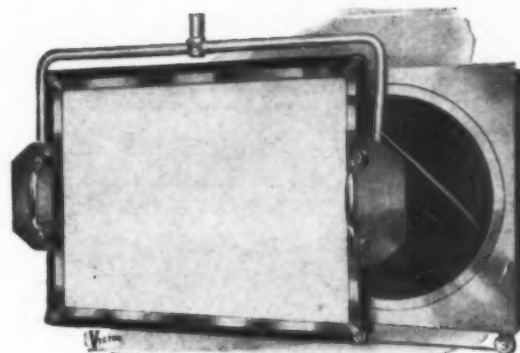
Just as the well known Victor-Kearsley Stabilizer functions to stabilize the tube current when "line" fluctuations occur, so does this new Victor timer (motor operated) function to measure exposure periods exactly. This is accomplished by an ingenious governing device which stabilizes the speed of the motor against even extreme "line" fluctuations. For "flash" radiography, it is incomparable—the highest milliamperages may be timed perfectly to 1-20th second, and consistently duplicated.

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This instrument of precision will prove invaluable to every Roentgen laboratory, being a timely contribution especially for the newer techniques involving "flash" radiography of the heart, chest, gastro-intestinal and gall bladder.

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DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by LULU G. GRAVES, 7 East 54th Street, New York
and MARY A. FOLEY, Director of Dietetics, Kahler Hospital, Rochester, Minn.

THE DIETARIUM IDEA

By Lenore Vinger, Rampart Dietarium,
Los Angeles, Calif.

DIETOTHERAPY tends to outgrow its own clothes. This expresses in a homely way the fact that the present system for the care of dietetic patients is often insufficient for actual requirements.

The dietarium has gradually come into existence and serves its useful purpose in endeavoring to fill definite needs. It is, therefore, necessary to deal with certain just criticisms of hospital dietetics. The writer would not for any selfish reason decry the recent great advances in institutional treatment of dietetic cases. There is, however, great need for further improvement, as indicated in every publication on hospital dietetics. To quote from a recent article by a distinguished local attending physician:*

"The function of the hospital is to treat patients, and in treating them the problem of nutrition is often predominant. This is, of course, generally recognized, but the fact remains that in most large institutions the attention to the dietary needs of the individual patient and the adaptation of meals to the patient's tastes and appetite are all too often overlooked. The great number of patients and the limited nursing staff will usually explain this lack of care, but these features cannot wholly excuse it. To each patient whose recovery requires an accurately weighed diet there are usually many whose recovery would at least be hastened by an appealing diet. How often one sees a sick woman without an appetite turning away from a tray laden with food enough for a longshoreman."

What Causes Loss of Appetite?

It may be well to give some thought to the causes for this unsatisfactory state of affairs. Hospitals, in their first development, are usually surgical. It would seem that some have never advanced beyond this stage, particularly the suburban and small city hospitals. Surgeons are usually ambitious and aggressive and tend to dominate such hospital staffs. The operating room and its equipment appeal to the hospital donor's sense of the dramatic. The diet kitchen seems too homelike, hence distinctly undramatic. Moreover, the number of hospital beds is often insufficient for actual requirements. The surgical case, if there be a lack of beds, must of its nature take precedence over the medical and especially the chronic dietetic case. For these and other reasons the dietetic development

of the hospital has usually lagged noticeably behind.

As a true example, in a recently completed large city hospital involving an investment of \$1,000,000, total provision for the dietetic department on the original plans included two gas outlets in the main kitchen. In contrast the operating rooms are spectacular. It is clearly evident that no member of the new hospital committee chanced to be interested in dietetics.

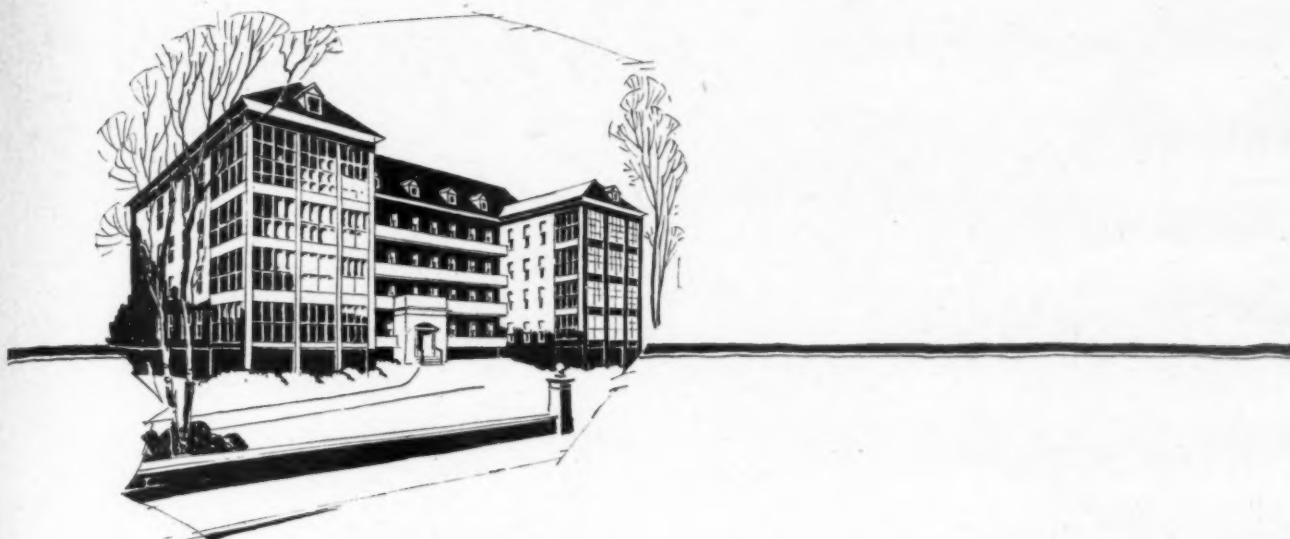
Cost Complicates Facilities

The other reason for inadequate hospital diet facilities is economic. Dietetic patients frequently require much more expensive menus than the average case; also, at times, increased and more accurate nursing attention. The cost of this service is often prohibitive to the strained hospital budget. Where special endowment is absent, as is the general rule, the dietetic department usually suffers. In some instances this need has been practically met by the development of clinics specializing more or less in diabetes and other dietetic diseases. These clinics and their research endowments have been a great aid to the poor dietetic patient, but unfortunately their number is necessarily limited. From the patient's own standpoint the combination of research and treatment does not always seem a happy one. A patient coming directly under my dietetic supervision from a nationally known research hospital complained that for a long period a sample of blood was extracted from his arm every day. I am aware of the great benefits medicine and dietetics derive from research study, but I maintain from practical experience as a dietitian that the treatment of dietetic cases has been unduly confused at times with research on such cases. Moreover, it devolves upon the dietitian to find an escape from the practical difficulties in the care of sufferers made uncomfortable by research studies.

That hospital environment is not conducive to the best results with the chronic dietetic case is generally admitted. These neurotic invalids are adversely affected by the crowding, bustle about the operating rooms, the accident case and other unpleasant phases of hospital life.

The hospital diet kitchen also has a tendency to become overburdened with routine instruction or the conflicting dietetic orders of several visiting physicians. Sometimes the dietitian must serve as purchasing agent and storekeeper for a large institution. Rarely can she come in direct personal contact with her patients. Therefore,

*See article by Dr. F. Peabody. *Journal of American Dietetic Association*. September, 1925, p. 133.



Maintaining a high standard of cleanliness with Oakite

Keeping a hospital free from all forms of dirt is a matter requiring constant care and the use of proper cleaning materials and methods.

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Oakite has a wide and varied use in hospitals. It may be used for cleaning white painted woodwork, walls, ceiling, and floors. It may be used for washing and reclaiming

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their food idiosyncrasies are neglected, and the results are unfortunate.

Next let us consider the sanitarium. I suppose we shall always need sanitariums for certain special types of diseases, such as tuberculosis, but at least in Southern California, the sanitarium idea has been ridden to death.

Here are a few of the sanitariums duly classified:

Fruits—raw fruit, grape, orange, grapefruit.

Fluid—milk, whey, goat's milk.

Cults—osteopathic, chiropractic, Christian Science, philosophic, theosophic.

Climate—sea air, mountain air, desert and sun cure.

Ideas—rest, family life, health farm, physical culture.

The list is actually much longer on the western coast where the medical cultist and pseudo-scientific faddist have thus developed the sanitarium for their own purposes. Though commercial successes do occur, yet in this section of the country a professionally and ethically worth while institution is indeed rare. The fundamental requirements are in one respect or another lacking. The medical staff is not composed of scientifically trained and experienced physicians, the nursing and dietetic work is deficient, or the equipment and its arrangement are poor.

Embody Best Features in Treatment

If not in the general hospital, research clinic, the commercial type of sanitarium or the home, how then, may we obtain ideal treatment for chronic cases? I believe that the true answer lies in a composite embodying the best features of all the above, as applied to treatment of our dietetic invalids. In the special research clinic we will leave the research where it properly belongs, but endeavor to apply each new discovery in dietetics as soon as it becomes practical. For example, the insulin treatment of diabetes has greatly modified the dietetic technique of diabetes with which we must be fully conversant. From the general hospital, we must have the ethical, experienced physician, scientifically trained in dietetic diseases. Medical treatment must be left wholly in his hands, but a skilled dietitian will, at his request, regularly visit each patient, both in the physician's company and again without him for elaboration of dietetic details. Thus she will both receive his dietetic orders after a helpful kind of daily consultation at the bedside and will execute them in detail, paying due attention to the food likes and dislikes of each patient. Again, from the hospital must come the thoroughly trained nurse, ready to carry out every medical treatment and meet every nursing emergency with skill and tact. From the home must be derived the quiet, peaceful environment and individual, sympathetic care, that every invalid craves and should never be denied.

Flexibility Needed in Diet Kitchen

The diet kitchen must be accurate, efficient and flexible. There should be no stereotyped diet. Any food article must be quickly obtainable. The menus must have many agreeable changes and indeed should be an improvement on the standard in the average American home in these respects.

Many ambulatory dietetic patients for various reasons (diagnosis, treatment or family) require special diets too elaborate or accurate to be obtained generally. A dietetic dining room for such out-patients serves a useful purpose. This adjunct to the Rampart Dietarium has been much appreciated both by the profession and laymen.

Although diabetic and dietetic specialists largely patronize such a specialized dietarium, yet the general internist or practitioner always finds it a real aid in his treatment of a dietetic case. When too busy to go deeply into the

DIETETIC PRESCRIPTION

To Rampart Dietarium, 667 S. Rampart Blvd.,
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Gastric, Hyperacidity..... Hypoacidity..... Lenhartz..... Sippy.....
Test Meal, Ewald..... Time..... Special (Designate).....
General, (Balanced, Highly Assimilable).....
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Milk, Straight..... Milk, Fluid..... C. C., 24 Hours.....
Nephritis, Salt, Restricted..... Minimal.....
Fluids, Restricted..... C. C., 24 Hours.....
Nitrogen, Restricted..... Grams.....
Oedema, (See Nephritis)
Obesity, Approximated..... Calories..... Weighed.....
Purin Low..... Free.....
Schmidt Intestinal Test Diet.....
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Vitamin-Rich Diet.....
For Diet Combinations, Check These Wanted
Insulin Administration
Preparation..... No. Units, A. M..... Noon..... P. M.....
Diabetic Recipes, Improved Diabetic Bread.
Patients' Weight Charts Recorded on Request.
Patient, M..... Tel.....
Address.....
Doctor..... Tel.....
Address.....
Special Directions

Dietetic prescription blank kept at hand in the office to aid the physician and patient in securing correct diet.

dietetic details of each case, the transfer of such responsibility to a competent dietitian proves a satisfactory arrangement.

In response to this need, we have developed a system of dietetic prescription writing as an aid to physicians and patients. The accompanying illustration is a copy of the blanks kept at hand in the office. The patient is sent to the dietarium with the dietetic prescription signed by the physician. In the case of the ambulatory patient, dietetic instruction is at once begun. The doctor is pleased because he can conveniently order the proper diet and rest assured of its prompt and accurate execution. His secretary is pleased, since she is relieved of typing long dietetic lists under pressure. The patient is pleased, as he receives what he wants, that is, immediate and efficient dietetic advice. The dietitian is pleased, since she increases thereby her usefulness and the number of her satisfied patrons.

Hospital treatment of dietetic cases, particularly diabetes, is oftentimes deficient in point of instruction of the patient. Diabetics frequently break diets, simply because the diets are monotonous or unpalatable, whereas it is quite possible for a modern diabetic diet to be tasty and varied to the normal degree. Not only must such patients be properly treated while under active dietetic supervision, but their future should be assured by thorough instruction in diabetic dietetics as applied to their particular case, including diabetic recipes and the culinary art itself. To this side of our work, necessarily, a great deal of attention has been paid with the result that it is seldom necessary for a diabetic patient to return for additional institutional care. When he does return, we endeavor to learn just why. Nowadays one thorough course of institutional treatment for diabetics should suffice.

To avoid accommodating the cultist, it is well to limit the professional clientele to members of the local county medical society whose recognition and friendly cooperation can thus be assured.

Such a composite unit must necessarily be limited in size or the keystone upon which its success rests, namely,

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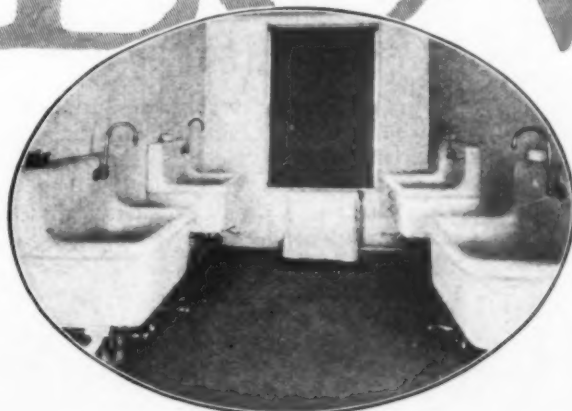
Oregon State Hospital
Salem, Oregon
Architect:
Lazarus, Whitehouse & Fouilhoux
Plumber:
J. A. Bernardi



St. Lawrence Hospital
Lansing, Michigan
Architect:
S. D. Butterworth
Plumber:
Wheeler-Blancy Company

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individualized dietetic and nursing service, will become dislodged. Perhaps ten to twenty beds might be safe limits. Practically, such an enterprise is adapted to development by a dietitian or dietitian and nurse.

Lest, however, I be compelled to patent the word "dietarium," I might add a few requirements. Because of its highly technical nature, only a very experienced and scientifically trained dietitian or dietitian and nurse should attempt such an undertaking. For good training there is no substitute. The confidence of the local medical profession can be secured only by real efficiency and tact. A certain degree of executive and business experience must be there in advance, or must be acquired at the cost of much time and expense. Patience, industry and economy all play their part in bringing success.

To be successful such a dietetic unit must be imbued with the same highly ethical ideals of service to the suffering as is the true physician himself. Dietetics is but a department of medical therapy. The dietitian should measure her success, as does the true physician, by the enjoyment of a really philanthropic and useful calling, an honorable, self-attained position in the community and an independent source of livelihood. A moderate financial return will then follow, not as a direct aim, but rather as an accompaniment of her successful professional career. This then is the dietarium idea.

CALIFORNIA DIETITIANS MEET

The third meeting of the California State Dietetic Association was held at the Anita Baldwin Clinic, Los Angeles, January 4, Miss McIntosh presiding.

Mrs. Earle introduced Dr. Saphro, who is executive head of the Child Welfare Department of the Los Angeles County.

Dr. Saphro gave the first talk which she has given since she returned to Los Angeles. She has just spent some little time at Johns Hopkins Hospital, Baltimore, and in Europe, studying problems of infant feeding. She told of her studies with Dr. McCollum and of the experiments that he carried on with his "rat family." Formerly the slogan of doctors has been: "Breast feed the baby," and it is a well known fact that some babies did not survive on the milk in spite of a perfectly healthy mother, so Dr. Saphro has collected some data that is interesting and valuable.

The work at Johns Hopkins was carried on with various feeding experiments on the rat to see what the effect would be on the young. Varying amounts of proteins, salts and vitamins were fed and the following results were observed:

Removal of vitamin A (butter fats, oils), resulted in blindness and sore eyes.

Removal of vitamin B, resulted in death and no growth.

Removal of vitamin C, resulted in scurvy.

Removal of vitamin D, resulted in rickets.

A mother cannot synthesize vitamins, they must be put into the food for the young, otherwise the mother will take phosphorous from her own bones for her young and in time will devour some of her young to be able to supply the remaining young.

Experiments were carried on in Germany during the war on healthy mothers who were getting a very fair diet. It was found that the babies were not growing normally and that the cause was a lack of vitamin A. Their butter fat and oils were not to be had in a sufficient quantity.

The babies in the Philippines suffering from beri-beri were found to be nursing from mothers who would not

eat enough vegetables, and they had to be taken from the breast immediately.

Healthy negroes from San Domingo living in New York were found to have babies with rickets and Albert Hess investigated and found that the only vegetables that they were eating were canned ones, and that they got very little fresh air, living most of the time in the house. At Johns Hopkins they are now teaching the negro mother to take cod-liver oil instead of giving it to the baby.

The following is the proper ratio of salts to prevent rickets:

.65 grams of calcium }
.41 grams of phosphorous } to 100 grams of food.

It has been proved that no over-feeding of the mothers will produce milk, but that the amount of milk is a thing that is hereditary.

Cod-liver oil given throughout the growth period is beneficial in regulating proper absorption of calcium and phosphorous. Liver plays an important part in the feeding of the child, but it is not yet definitely determined what it does. Vitamin E produces fertility and is found in lettuce and some grains. Further experimentation is needed.

A new book by Dr. McCollum was mentioned which is practical and very readable. The title is "Food, Nutrition and Health," and it may be obtained at East End Post Station, Box 45, Baltimore. Reference was made, also, to an article by Dr. Nina Simmens, assistant to Dr. McCollum, entitled "Observation on Reproduction and Rearing of the Young by the Rat, as Influenced by Diet."

An informal discussion followed and the president then thanked Dr. Saphro for her interesting talk. The minutes of the last meeting were read and approved.

OFFICERS CHOSEN FOR CHICAGO ASSOCIATION

The February meeting of the Chicago Dietetic Association was held at the John Crerar Library. The speaker of the evening was Dr. Fryer of the Fryer Biological Laboratories, Chicago, who talked on the work of his laboratory. He dwelt particularly on the history, experiments and results from acidophilus milk.

The following officers were elected for the coming year: President, Theresa Clos, 830 S. Michigan Ave.; vice president, Gudrum Carlson, 509 S. Wabash Ave.; secretary, Florence E. Nolan, 5601 N. Crawford Ave., and treasurer, Annette Walker, Edward Hines Memorial Hospital, Maywood, Ill.

The following committee appointments were made:

Membership, Mrs. Esther Ackerson Fischer; nominating, Eleanor Dustin, Chicago Lying-in Hospital; publicity, Isabelle Randall; publications, Mrs. Rose Straka Fowler; program, Gudrun Carlson, and revision, Emma Aylward.

NEW YORK DIETITIANS MEET

The February meeting of the New York Association of Dietitians was held in South Hall, Russell Sage Foundation building under the chairmanship of Dr. Emily C. Seaman. The subject discussed was "The Educational Value of Social Nutrition."

Discussion of various phases of the subject was led by Lucy Gillette, director of nutrition, A. I. C. P., Misses Bertha Edwards, supervisor of nutrition, and Frances Benjamin, supervisor of education work, East Harlem Nursing and Health Demonstration, and Dr. George Baehr, director of metabolic clinic, Mt. Sinai Hospital.

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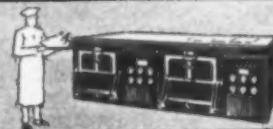
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OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by LOUIS J. HAAS, Director of Men's Therapeutic Occupations, Bloomingdale Hospital, White Plains, N. Y., and
MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.

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DEVELOPING INSTRUCTION PLAQUES FOR THE BLIND TEACHER

By Louis J. Haas, Director of Men's Therapeutic Occupations, Bloomingdale Hospital,
White Plains, N. Y.

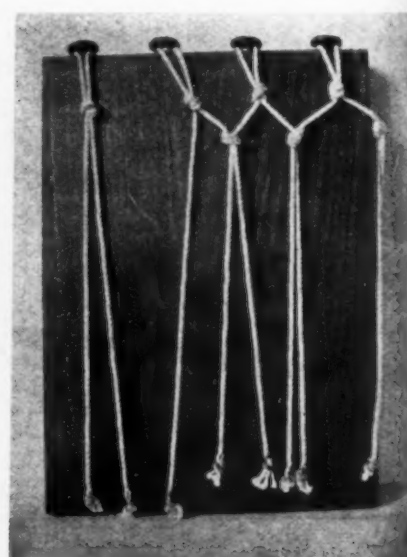
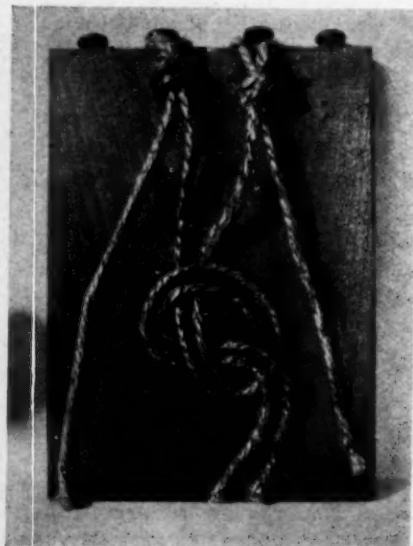
THE therapeutic value to the patient of feeling that in spite of the limitations of hospital residence he can still, through occupational therapy, be a useful member of society, cannot be overestimated. This is now a well established principle in occupational therapy for the mentally and nervously ill.

The recognized principles through which this treatment measure works are still few in number, but in 1915 with the exception of a few people who were working with the mental and nervous, all occupational therapists believed the sole object of this treatment measure to be diversional. One department that at this early date was already developing a technique that tended away from the diversional school indicated the recognition of the new principle in this statement: "The therapeutic value to the patient often lies largely in making the craft project as interesting and beautiful, but essentially useful and serviceable, as is possible within the limitations of the hospital and treatment classification." While in no way depreciating the value of diversional occupational treatment, where clearly indicated, the recognition of the new prin-

ciple initiated the thoughtful study and adaptation of various projects to occupational therapy treatment, the use of which we now find of great value.

This development in the past ten years in one department has followed this sequence: Repair and upkeep of certain hospital and occupational equipment, making new equipment in the case of occupational apparatus especially designed to meet the needs of our own department; designing and making new equipment (even designing new techniques) to make possible the more efficient occupational therapy treatment of certain groups of patients in our own hospital and especially handicapped groups in other hospitals.² Parallel with the above has developed the wholesome practice of having the patient in certain shops make special accessories³ that effect economy and produce better quality in the product of the treatment of the very sick patient.⁴

Recently along with the above has developed the interest in the occupational therapy upkeep problems; repairing and replacing certain tools that give way under the unusual wear, but more largely the study of the reasons



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for the breakdown and the designing and constructing of special tools that meet and overcome the destructiveness of confused and inexperienced patients. It seems needless to say that the patient who is privileged to engage in this form of occupational treatment receives through the more normal satisfaction, reactions that are highly therapeutic. Much of this experience and development has been published, as indicated, and more recently the entire experience of this department has been presented in book form.⁵

It would seem that eventually the material for carrying on such phases of occupational treatment would become exhausted, but in reality this field is unlimited and its consistent development indicates and makes possible further development.

Attention must also be called to the fact that not only is the patient, who may engage in this form of occupa-

tional treatment, and the one directly affected by his labors, helped, but the atmosphere created thus permeates the entire department and benefits all. Thus, recently many of the patients in the basketry shop have had a special interest in making a number of model baskets for the New York State Commission for the Blind and more recently the carpenter shop group has become interested in redesigning and simplifying the laundry bag loom,⁶ so that it would be suitable for the use of certain blind students. When it was found that this had served the initial worker, but would not reach a special problem case, because the local blind instructor was not familiar with knot work or netting, the problem of developing the means of teaching the instructor through a series of special demonstration plaques was undertaken. As the solution of this problem seems to contain data of interest to others than the local group, it will be presented in detail.

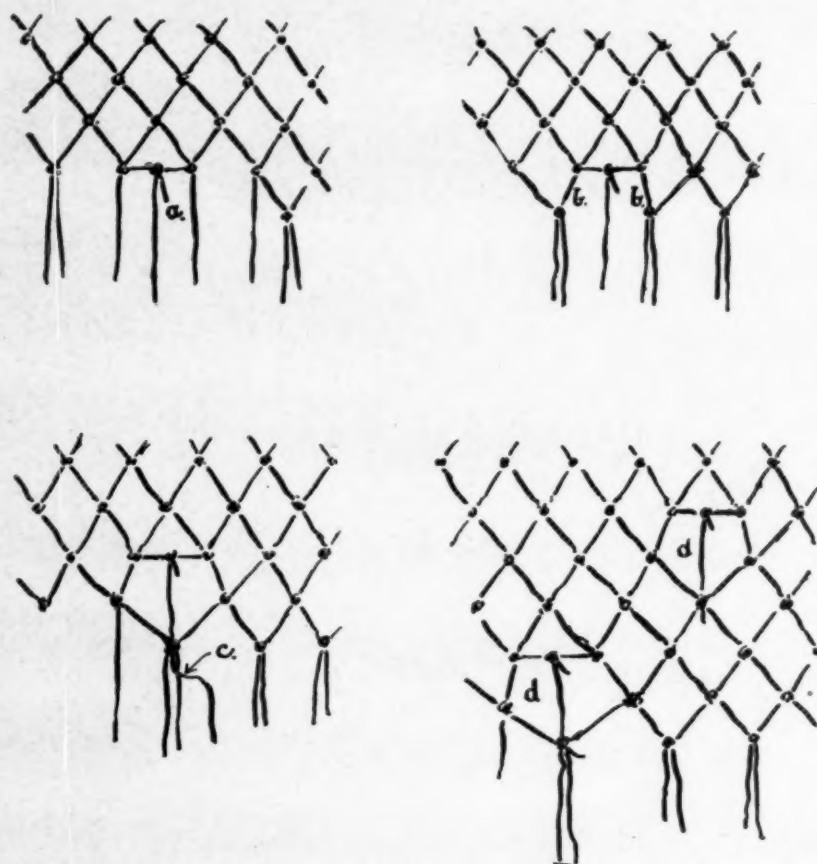
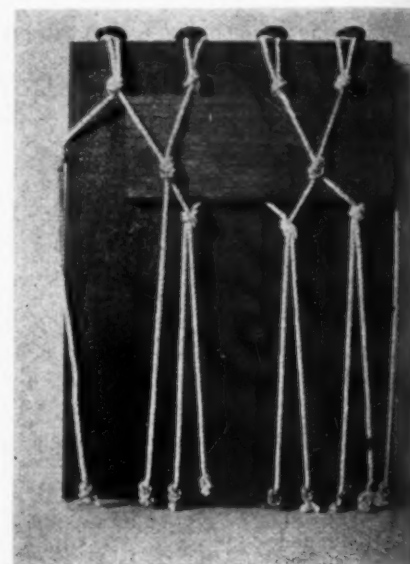
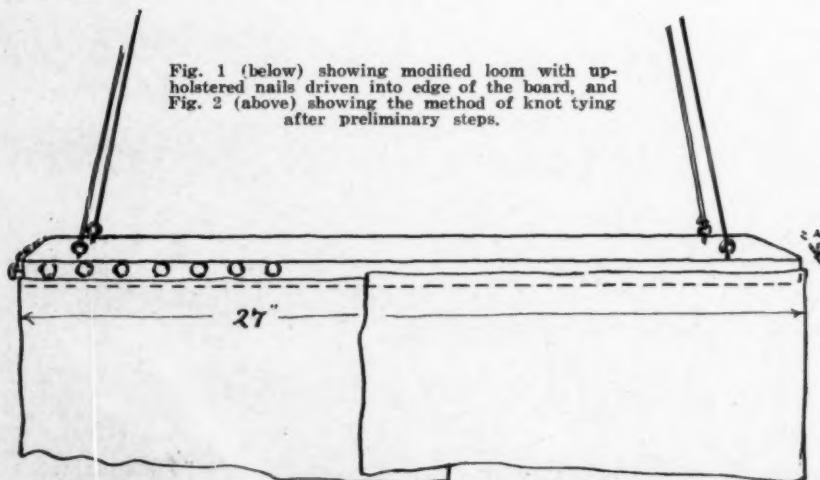
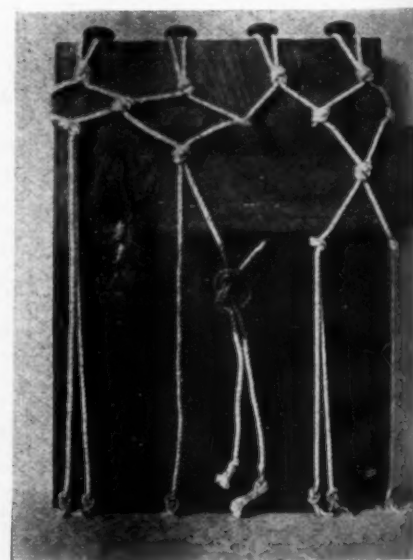


Fig. 1 (below) showing modified loom with upholstered nails driven into edge of the board, and Fig. 2 (above) showing the method of knot tying after preliminary steps.



Plaque 4, used to show the continuation of the introductory steps upon insertion of board.



Plaque 5, used to show the steps after the knot work has become well started through the use of the board.



Better, More Economical Refrigeration

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The modified loom is a board 1 by 6 by 27 inches with upholstered nails driven into the edge of the board (Fig. 1). The further construction of this loom and its use will be explained by the illustrations of the series of demonstration plaques and the instructions that were attached to the back of each plaque. The loom and plaques were made as occupational therapy treatment and the instructions were typed and attached to the plaques. The same data were also set in Braille.

Following are the data accompanying the plaques:

1. This knot is used in constructing bags upon the bag frame.

The bag frame is a board 1 by 6 by 27 inches with nails placed about 1 inch apart in the 1 inch face. Nails extend $\frac{1}{4}$ inch and should have large flat heads. The number of nails and spacing control the number of mesh to a row while the mesh stick controls the size of mesh. The mesh stick for the laundry bag measures $\frac{1}{4}$ inch by $\frac{1}{2}$ inch by 6 inches. The frame may be hung from four cords for convenience in working. If a piece of stiff paper is thumb tacked to the edge of the frame under the cord, it will separate the sides of the bag and avoid confusion.

2. To warp, cut sixty-eight, 9 feet lengths of number 15 cord. The lengths should be 36 inches longer than twice the length of the bag it is desired to make. Take a length, bring ends together and slide through fingers till middle is reached; take resulting loop and tie knot at a point $\frac{1}{4}$ inch in from loop. Hang this length on warp nail by the loop. Prepare and hang another loop, proceeding until bag frame is warped.

3. Take a pair of cords from adjacent looped lengths and tie (using the knot) placing the knot at the proper distance below the row of knots formed in stage number 1. Take up the next pair of adjacent cords and knot, taking care to bring to the level just established. Proceed until this row is complete. Note that the pairing of adjacent threads by the new knot separates the threads paired by adjacent knots in the row above.

4. The mesh stick is used to control the size of mesh when the third row of knots is formed. The mesh stick separates the adjacent pairs and the new knots are tied up tight to the stick on its under edge. As meshes are completed the mesh stick is slipped forward.

5. The construction of the bag continues as just described, row after row of meshes being tied over the mesh stick as indicated in stage number 3. When the bag is of sufficient depth it is taken from the bag frame, the bottom edges brought together and the threads from the opposite sides paired and tied, thus closing the bottom. A heavy draw cord is placed through the loops of the upper edge of the bag and it is complete.

Knot Stiffened With Shellac

The demonstrations are all made of the same cord used in making the laundry bag, with the exception of the knot which is made of a much heavier cord. The knot was made and held into its open formation by pins, filled with shellac which stiffened the rope so that the pins could be removed. The ends of all cords are knotted to keep from fraying. In the demonstrations, the ends of the cords were fastened by small nails driven through the knotted ends. The loom and demonstration plaques are accompanied by a sample bag. Experience has proved this method satisfactory to all concerned.

By making certain changes in the set up of the bag frame, circular nets for other purposes can be constructed upon it. Using a number 24 cord and setting up a looped pair of threads to every other nail and using a mesh stick $\frac{1}{4}$ by 2 $\frac{1}{2}$ by 10 inch, nets for the basket ball goals

can be made. This involves no radical change in the knotting construction.

Dip nets could be made as large as the bag frame, or a smaller frame can be constructed with a relatively smaller number of nails. Cord number 15 would be used (in some instances lighter weight could be used) and set up as instructed for the laundry bag, estimating the length of cord as indicated. When a sufficient quantity of the net has been constructed, to begin to decrease the circumference, the worker takes a pair of adjacent threads and without the aid of the mesh stick ties a knot so high that the result is not a diamond mesh but an equilateral triangle with knots at the three corners and a knot at the center of the basket. See Fig. 2 (a).

One of the pair of threads below the central base knot is cut. In tying knots of adjacent diamonds the sides next to the triangle are shortened as shown in the figure. He then continues with the regular mesh until another thread is dropped by the same process. The number of threads to be dropped is decided by the amount of taper desired. The thread is dropped in the next row at these fixed points in the following manner: The worker takes adjacent threads on each side of the triangle and, taking with these the single thread suspended from the center of the triangle's base, ties a three cord knot and clips the thread that came from the triangle, $\frac{1}{4}$ inch below the knot just made, as shown at (c) in Fig. 2. He proceeds with regular diamond meshes until the next triangle mesh is reached, at which point the thread is dropped in the manner just described. See Fig. 2 (d.d.).

Unless it is desired to taper the net rapidly, a row or more of regular mesh is made before the next set of threads is dropped. When the next set is to be dropped care should be taken to place the diamond meshes between those in the above row. The net may be narrowed thus until, by tying a few threads, the bottom will close in a round point.

REFERENCES

- ¹ Efficiency Equipment, *Industrial Arts Magazine*, August, 1918.
- ² Equipment for the Bedside Occupation of Men, *Industrial Arts Magazine*, Oct.-Nov., 1918, and *Hospital Progress*, Aug-Sept., 1920.
- ³ Circular Bag Weaving, *Archives of Occupational Therapy*, Dec. 1923 and *Weaving Frame for Bedside Occupational Therapy*, *Occupational Therapy and Rehabilitation*, April 1925.
- ⁴ The Producing in the Carpenter Shop and Metal Shops, Baskets and Tray Bottoms, Lamp Skeletons, etc.
- ⁵ Occupational Therapy for the Mentally and Nervously Ill, by Louis J. Haas, Bruce Pub. Co., Milwaukee.
- ⁶ See Equipment for Bedside Occupation of Men, *Industrial Arts Magazine*, Oct.-Nov. 1918, or chapter No. 6, pages 79 to 83, *Occupational Therapy for the Mentally and Nervously Ill*.

GRADUATING EXERCISES HELD

Twenty-one students graduated from the Boston School of Occupational Therapy Friday evening, December 4. Dr. John D. Adams, chairman of the board of directors of the school presided at the exercises and three prominent speakers took part.

Dr. Goldwin W. Howland, University of Toronto, spoke of the progress of occupational therapy throughout Canada. Mrs. Eleanor Clarke Slagle, secretary-treasurer of the American Occupational Therapy Association, told of the growth of this work throughout the hospitals in this country.

Rev. Henry K. Sherrill, rector of Trinity Church, Boston, and a member of the board of directors of the school, gave a brief talk, dwelling on the spirit of service. The dean of the school, Marjorie B. Green, awarded the diplomas.

Approximately two hundred guests were present and at the close of the exercises refreshments were served.



Every window seems sunny with Boott Scrim

THERE is such a clear, cheerful cleanliness about Boott Scrim that it gives an air of freshness and gaiety to any window it dresses — yet this beauty does not mean that Boott Scrim is not practical to the last degree. Its wearing qualities are phenomenal. It cleans easily and well, sturdily withstanding the constant antiseptics that hospital laundries must perform use.

And in the matter of price Boott Scrim has an instant appeal to the careful buyer, for both in original and replacement cost it is inexpensive. The firm, double-heavy hem adds greatly to the long life of these curtains, stoutly withstanding the wear from mangling, hook-racks or ironing. Then, too, Boott Scrim need not be starched, just ironed lengthwise—a great labor-saving.

Boott Towels, Toweling, Wash Cloths, Scarfs and Bibs are other practical members of the Boott family which find a ready use and appreciation in the up-to-date hospital.

If your hospital does not use Boott Products you should familiarize yourself with them at once—for they make for both economy and efficiency. If your supply-house does not have a complete line to show you, we should be glad to have you get in touch with us direct and we will see that you are supplied. Write today for samples and prices to

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BOOTT SCRIM

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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

HELPING BOILER PLANT INSTRUMENTS TO OPERATE EFFECTIVELY

By Russell Byron Williams,
Chicago

COMBUSTION is that process by which oxidation of fuel is effected. It is a chemical change in the relation of the elements contained in the fuel and the oxygen of the air. All fuel, regardless of type, whether gas, liquid or solid, contains combustible matter, the principal element of which is carbon. It is the oxidation or combustion of these elements that creates or generates heat.

Since all fuels contain only a limited or specific amount of heat, the more complete the combustion the more heat liberated. Or, to say it in another way, if all the combustible material contained in the fuel fully unites with the element oxygen, then the fuel gives off its total amount of heat to the products of combustion.

To liberate the total amount of heat contained in any fuel, it is necessary that each atom of carbon (C) should unite with two atoms of oxygen (O). This will form a compound known as carbon dioxide (CO₂). Knowing this, it will be readily appreciated that if the supply of air, or oxygen, is insufficient, some atoms of carbon will be compelled to unite with only one atom of oxygen and thereby escape in the form of carbon monoxide (CO). Where this condition exists, only a scant 40 per cent of the heat of the fuel is liberated for use, while 60 per cent of the heat escapes up the chimney in the form of CO, carbon monoxide compound.

Air Excess Wastes Heat

If the supply of air is more than necessary for the requirements of combustion, the excess of free air passing through the fire box carries enormous quantities of heat with it up the stack. For this reason an excess supply of air always results in a great loss of heat, usually about 50 or 60 per cent, while, as explained above, an insufficient amount of air will cause an equally large loss.

Because all gases must pass up the smoke stack and result from the prevailing fire box conditions, it is obvious that the best possible test for the varying degrees of combustion would be the percentage of carbon dioxide (CO₂) in the flue gases. Admitting this, it will be seen that to secure a sample of the flue gases, analyze that sample by chemical processes to discover the percentage of CO₂, is the way to determine the degree of combustion efficiency.

However, the conditions of combustion in the fire box are constantly changing. And because a CO₂ analysis of flue gases indicates the efficiency of combustion only at the time the sample is taken, which condition may be radically changed thirty minutes later, it is essential that CO₂ analyses be made frequently. There are available, small inexpensive hand instruments, with which CO₂ analysis may be made with comparatively little work. With such an outfit, however, no engineer could be expected to read the CO₂ content more frequently than every two or three hours. Because combustion conditions change rapidly and radically such readings, while satisfactory, do not afford a true picture of combustion efficiency without which no engineer can know whether he is wasting coal or enduring other costly conditions.

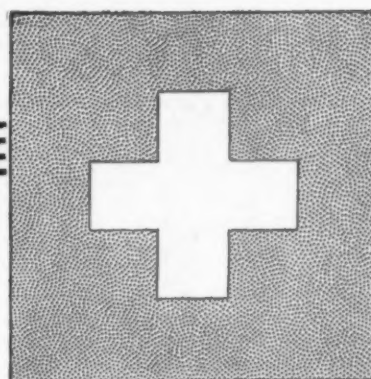
Solving Combustion Conditions

The solution to the problem of maintaining proper combustion conditions lies in the installation of an automatic CO₂ recording instrument. Such instruments are manufactured by a number of reliable firms and can be installed without undue expense. It has been proved, time and again, that the conditions such instruments reveal (by sampling and analyzing the CO₂ content of the flue gases every 120 seconds) thereby making possible needed corrections and subsequent savings in fuel, make the investment earn dividends ranging from 50 to 650 per cent. No building, no hospital, no plant having a boiler of 150 h.p. or over, and a credit sufficiently high to permit borrowing money at 8 per cent (if available money is not at hand) can afford to continue guess-work combustion or be without a reliable CO₂ recording instrument.

Unfortunately, some engineers have been lead to believe, or at least have expected, that CO₂ recorders will operate accurately and continuously without attention for months at a time. But boiler room instruments are no different from any other kind of an instrument, and because this is true they require a certain amount of attention and care.

Not long ago I was talking to the engineer of a large hospital who assured me that he had CO₂ recorders on every one of his three boilers, but he also stated that these instruments had been inoperative for over two years.

Laundry convenience in the hospital



AMONG the factors that contribute to the convenience and efficiency of the hospital laundry are rapid drying of clothes, quick ironing in modern gas-heated ironing machines and general cleanliness and freedom from dirt.

These conveniences depend directly on the availability of a satisfactory gas service. For hospitals not located near a supply of city gas, Pyrofax makes these laundry conveniences possible.

Pyrofax gas resembles natural gas and is shipped to the hospital in steel cylinders. It is non-toxic and burns with a clean, hot flame free from soot or odor. It can be used on any standard gas appliance—ranges, hot plates, Bunsen burners, and laundry ironers.

The Pyrofax installation consists of a substantial enameled steel cabinet which houses the cylinders and fittings. It is placed outside the building and the gas is piped from it through ordinary gas pipe to the stoves, burners and other appliances. It is listed as standard by the National Board of Fire Underwriters.

Any further details will be promptly furnished on request. May we not send you our circular and booklet describing Pyrofax?

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When asked the reason for their disuse he replied: "They required too much attention. Every two or three weeks we had to change the caustic solution; then the pipes were forever clogging, or the filter required cleaning." He did not feel that the results of his labor justified his effort. However, upon investigation, I found that the engineer had been using his recorder daily for the sole purpose of hanging the charts on a nail until that nail became overloaded, at which time he would throw away the entire bunch and start again with a clean nail.

This instance is not so outstanding as might be imagined. If the reader could visit several dozen boiler plants in company with the writer, he or she would realize that the instance cited merely indicates the avenue of reasoning followed by too many engineers. Under such conditions, of course, the instrument could be of little or no value. If a log book or some other history sheet is not employed to record and analyze the findings of the instruments, to the end that a standard of performance may be set up and a goal constantly sought, what value can the whole procedure have? Of what value are calculations and totals if the results are not analyzed in the light of performance and put to work? I feel safe in saying that had this engineer recorded his charts in a log book or on a graph he would have found the work of maintaining the instrument exceedingly small in comparison with the value derived.

Where the Difficulty Lies

Ninety per cent of all CO₂ recorded difficulty lies in either the sampling tube or the pipe connections. Under no circumstances should the sampling tube be placed closer to the fire-wall than eighteen inches, since the infiltration of cold air through the wall tends to chill the gases, which in itself changes the CO₂ content and makes the sample non-representative. Open end sample tubes should not be used, as these will plug with soot and other foreign matter nearly as rapidly as they can be cleaned. In my opinion a porous filter, or asbestos lined tube, placed directly across the uptake, will give the best results over a period of time and provide the fairest representation of the composite gases.

Whether or not the sampling tube is functioning properly can be seen by the indicator bottle. When bubbles become small and are infrequent, the sampling tube should be removed and cleaned immediately. Some engineers have tried, in the past, to clean the sampling tube by steam pressure, thus obviating the necessity for removal. This method is seldom satisfactory since the soot, when it comes in contact with the steam, becomes a paste and adheres all the more closely.

The caustic potash solution should be changed once in three weeks if the boiler is under twenty-four hours' load. When a boiler is on load only twelve hours a day this solution may remain in good condition for five or six weeks. Pipe and pipe connections should be absolutely tight at all times, and should be kept clean. Water holds foreign matter in suspension and this tends to accumulate and clog the small openings of the pipe. This is, perhaps, the most frequent cause for recorder trouble. See that the pipe is free of accumulation and is tight. Iron pipe (not steel) and cast iron fittings should be used. Avoid fittings by bending the pipe but care should be exercised not to flatten the pipe, when bending. Only ground, air tight cocks should be used for the manifold and other distributing outlets.

CO₂ recording instruments are not dissimilar to other instruments in that care and attention are required for their proper operation. They are unlike other instru-



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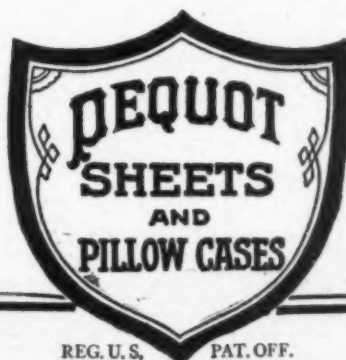
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Do the Work of 10
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The importance of spotless cleanliness can not be over-estimated.

In no building is sanitation carried so near the *point of perfection* as in hospitals. The very nature of their use demands that the highest degree of hygiene be practiced at all times.

You will be agreeably surprised at the thoroughness of sanitary conditions that can be attained when your scrubbing is done with a "*Lincoln.*"

Your patients will appreciate the quietness with which it operates.

Your cleaners (men or women) will appreciate the ease of operation.

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ments, however, in the volume of dividends they will return for such upkeep. No other boiler room instrument holds such potentialities for economy as the CO₂ recorder. In ordinary practice this instrument should be given a superficial inspection every day and a thorough examination once a week.

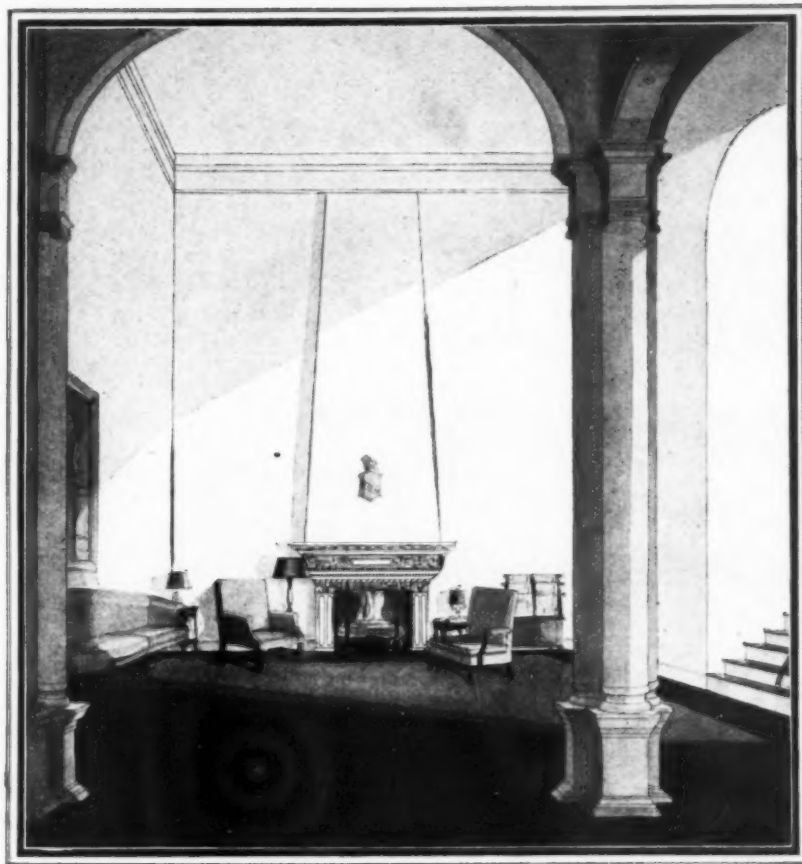
In the event of trouble or inaccurate readings it will save time and effort if the engineer will observe the following symptoms: If the pen swings out of the working range, or draws an irregular line while operating on air, there may be a leak in the fittings or cover of the potash tank, the gas tube leading into the potash tank may be partially closed, or the oil may be at an improper level in the oil cup. If the gas float strikes the guide above it and forces the oil out of the cup it may be that either the relief tube or the opening from the potash tank is plugged, the potash level may be too high above the sight glass in the tank, or all the water from the water column may not have been removed. If the indicator bottle shows no bubbles, the trouble may be that the water does not flow freely through the water jet when the cap does not form an air tight union on the bottle or the gas pipe may be plugged either at the intake sampling tube or between the indicator bottle and water jet. If the water does not flow from the instrument intermittently, see that all connections are air tight and clean the drain pipe. If the instrument does not check with the hand orsat the solution of caustic potash may be too weak, the gas connections may not be tight, or the oil level may be too low. While these suggestions little interest the superintendent whose time, for the most part, is taken up with more important things, they are well to know, or to keep at hand in the event the engineer complains that his recorder is not working and wants to incur the expense of a service man from the factory for its adjustments.

Other Useful Instruments

There are many other instruments that might profitably be employed in the average hospital boiler plant and which are now seen only infrequently, even in the larger institutions. Steam flow meters, draft instruments, pressure indicators and recorders, coal meters, pyrometers, thermometers, and other indicating instruments all have their place and sphere of usefulness. All require only a reasonable amount of attention, but if supplied with this amount, they will function with distinct benefit to the institution. And it must not be forgotten that a dollar saved in the boiler plant or laundry means an additional dollar released to the extension of therapeutic service.

To the non-technical superintendent the above listing of instruments may seem quite beyond the bourne of economic possibility. But the number, type and size of instruments that can be profitably employed depends entirely upon the size and character of the boiler room. It is always best to install the minimum number of instruments that will permit the engineer to approximate operating efficiency. Then, if savings are sufficient to justify the initial investment, more instruments should be added.

For a small plant, say, two 150 h.p. boilers, or with a hospital of seventy-five or eighty bed capacity, the initial equipment should include an indicating steam flow meter which will permit the use of one indicating device but which has three orifice plates, one for each boiler and one for the main header; a steam thermometer for the feed water; a recording CO₂ analyzer and a hand orsat. This initial set can ordinarily be obtained and installed for



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—a guarantee made possible by the exclusive Rice Process of manufacture.

Sold in 55- and 30-gallon churn-equipped steel drums, and in cans from $\frac{1}{2}$ pint to 5 gallons. Where more than one coat is required, use Barreled Sunlight Undercoat first.

Send the coupon for a free copy of our illustrated booklet, "Interiors of Lasting Whiteness," and a panel painted with Barreled Sunlight.

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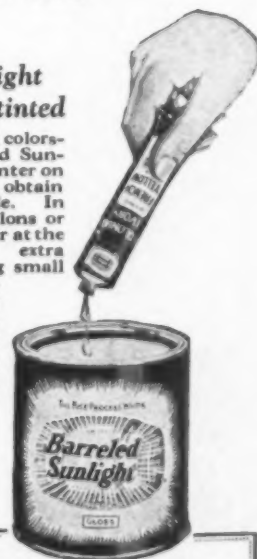
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By simply mixing colors-in-oil with Barreled Sunlight white, the painter on the job can easily obtain any desired shade. In quantities of 5 gallons or over we tint on order at the factory, without extra charge. For tinting small quantities our dealers carry handy tubes of Barreled Sunlight Tinting Colors. They are almost liquid, blending easily and quickly with Barreled Sunlight.



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Please send us your booklet "Interiors of Lasting Whiteness," and a panel painted with Barreled Sunlight.

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The Maimin Gauze and Bandage Cutter requires no special installation, and connects to any light socket. It will cut cleanly, with absolute accuracy, saving 90 to 95% cutting time.

Note the newly patented Bandage Carriage, which measures, and at the same time assures a perfectly cut bandage.

Maimin Gauze and Bandage Cutters with Self Measuring Gauges

This gauze and bandage cutter was designed and constructed especially for hospital use. It can do a whole day's work in a few minutes. It not only saves time and eliminates unnecessary manual labor, but assures you of any size dressing, as required.

It cuts three bolts of gauze in one operation, 1500 bandages an hour, absorbent cotton several inches in height, and a whole roll of cellucotton in a half hour.

It contains a five-inch blade, and is very light, weighing but 16 pounds. Being mounted on rollers it can be moved about very easily and freely.

Notice that the operating switch is located near the thumb. A knife sharpener is mounted on the machine, also controlled from the handle, and furnishes a razor-sharp edge on the knife in a few seconds. Always ready—nothing to get out of order—practically no upkeep costs.

Write for a free ten day trial, to convince yourself of the value this Maimin Gauze and Bandage Cutter, fully equipped with self measuring gauges, and the NEW BANDAGE CARRIAGE.

H. MAIMIN CO., Inc.
MANUFACTURER

251 West 19th St.

New York, N. Y.

a sum not exceeding five hundred dollars.

With such instruments the weight of steam from either boiler or both may be obtained and recorded on eight or ten minute intervals; the feed water temperature may be maintained at the highest possible point. This, too, when calculated with the steam pressure, quality of steam, weight and content of coal, and boiler horsepower developed, should result in an accurate analysis of boiler efficiency. Through the CO₂ analyzer the fires, damper, etc., may be regulated and manipulated to afford maximum results. If the experiences from such a set should result in a 5 per cent increase in efficiency the set will have far more than paid for itself and the hospital will be justified in adding other instruments, such as a recording flue gas pyrometer, draft gauges for measuring both the pressure drop across the boiler and across the fuel bed, and individual flow meters for both boilers.

Because the mere installation of instruments will not effect economies, because the instruments of themselves will do nothing to increase productivity or decrease fuel costs, but only the intelligent analysis of the performance they indicate and unswerving obedience to the adjustments they deem necessary, hospital superintendents and engineers get value out of their instruments only in proportion to the maintenance and care given them. That they will effect almost astonishing economies has been proved time and again. St. Luke's Hospital, Chicago, for instance, is getting splendid results from its battery of instruments and would not think of operating the plant without them. Other instruments in daily use in smaller institutions (down to seventy-five bed capacity) are saving from 5 to 20 per cent of the annual fuel bill. That they are a liability rather than an asset when there is a total absence of record analysis or insufficient maintenance has also been proved. It is up to the individual hospital superintendent—up to the engineer, whose work is a part of the superintendent's responsibility—to see that the institution gets nothing, little or much from the boiler room instruments.

CAN THE SMALL HOSPITAL HAVE ELECTRIC REFRIGERATION?

Superintendents of small hospitals seem to take it for granted that automatic refrigeration is not for them. This may have been true several years ago but things have changed so rapidly in this branch of industry that it is now possible and profitable for even the smallest hospital to have electric refrigeration. Its advantages over ice are so obvious that there is no question about its value for hospitals. Points to consider when selecting such equipment are: Is it fool-proof? Does it generate enough refrigeration to take care of an overload? Can the manufacturer give speedy service? Is he financially sound? This is important because replacements may be necessary from time to time. It does not pay to purchase from companies that are liable to be out of business soon.

HISTORIES SHOULD BE COMPLETED

Since it is a habit with interns, particularly the newer ones, to leave out the minor, and sometimes major, points in patients' histories, one day of each week is set aside as "History Completion Day" by one of the middle-western hospitals. On this day every intern is required to go over all the histories of his discharged patients, bring them up-to-date, and make them ready for filing.

This setting aside of a special day for history completion develops more detailed histories.



Four times more absorbent than ordinary cotton!

*—one of 8 reasons why 2383 hospitals
are using CELLUCOTTON*

MORE effective—more economical than ordinary cotton—Cellucotton is recognized today as the most useful absorbent ever known to hospitals. Born during the great war its manufacture has grown rapidly to meet a constantly increasing demand. Hospitals all over the country are using it—from 100 to 9000 pounds a year apiece.

Manufactured from a very fine pulp derived from the best northern spruce, Cellucotton is separated from all foreign matter by a special process. It comes from the machine a soft, pure, fluffy cellulose, possessing tensile strength and remarkable absorbency.

The inherent properties of Cellucotton plus the very strict hygienic principles applied throughout production, make it adaptable to the most

Eight Points of Cellucotton Superiority

1. Cellucotton absorbs from 4 to 8 times more drainage before saturation than most grades of absorbent cotton.
2. It retains more liquid before leakage takes place.
3. It absorbs 3 to 5 times as fast as absorbent cotton.
4. It draws fluid against gravity. It serves as a wick instead of a dam.
5. Fluid penetrates to every part of the Cellucotton dressing.
6. On account of its bulk it makes more dressings per pound than absorbent cotton.
7. It is lighter, cooler and more comfortable for the patient.
8. Its cost is so low as to make it one of the most economical forms of absorbents.

exact requirements of medical and hospital usage.

Cellucotton is inexpensive, too

And Cellucotton is not expensive. Despite its superiority its cost is less than that of the cotton it replaces.

Whether you use Cellucotton or not we urge you to take advantage of the offer below. Just fill in the coupon, check any or all items wanted and mail to the Lewis Manufacturing Company (Division of Kendall Mills, Inc.), Walpole, Mass. Branch Offices: New York, 302 Broadway; Cleveland, 952 Leader-News Building; San Francisco, 843 Pacific Building; St. Louis, 1338 Syndicate Trust Building; Philadelphia, 21 S. 12th Street; Chicago, 30 No. La Salle Street.

LEWIS MANUFACTURING CO., WALPOLE, MASS

Please send me the items I have checked.

Set of sample Cellucotton dressings.....

A generous Cellucotton sample.....

The "Receipt Book" of Cellucotton uses.....

Quotation on trial order of 100 lbs.....

Name.....

M. B. 4-28

A staunch ally of modern medicine

In this day of preventive medicine, Kellogg's ALL-BRAN is a valuable aid to the profession. It not only relieves constipation, but **prevents** it. Promotes regular, natural elimination of the intestinal tract.

Physicians and nurses, both, know they can rely upon Kellogg's because it is 100% bran. Because it provides the "roughage" or bulk so necessary to correct faulty elimination—in a quantity no part-bran product can possibly carry.

Kellogg's ALL-BRAN is a prescription patients like to take. Children love it. Cooked and krumbled by a special process, Kellogg's has a delicious nut-like flavor. Delightful as a breakfast cereal—there are many other appetizing ways to serve it.

Sold by all grocers. Served everywhere. Made by Kellogg in Battle Creek, Michigan.



What U. S. P. is to drugs, ALL-BRAN is to bran foods.

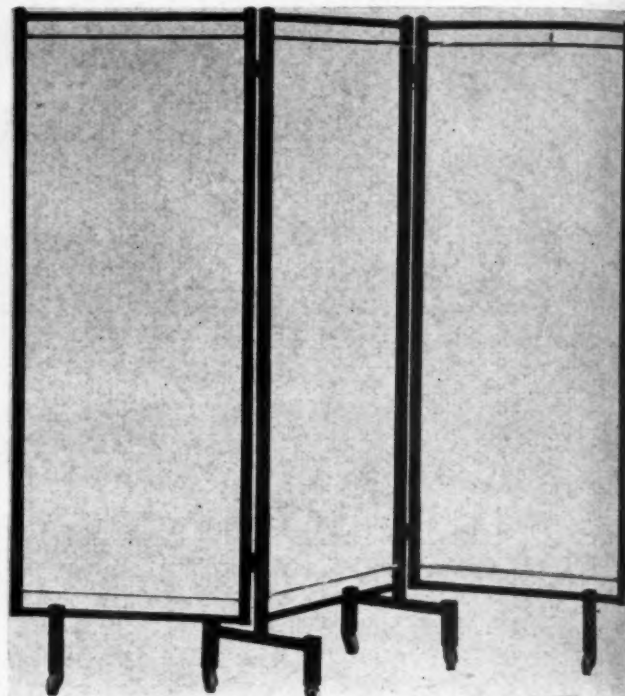
Send to the Kellogg Company, Battle Creek, Mich., for recipes and health pamphlets.

Kellogg's
the original ALL-BRAN
—ready-to-eat

FOLDING SCREEN FOR SICK ROOM

Sturdy but graceful in appearance, and compact when desired, is the triple screen recently designed for sick room use.

Double action hinges permit folding the side wings flatly against the center panel from either side, minimizing the necessary floor and wall space when not in use as a



screen. The easy rolling, two-inch diameter, rubber wheel casters allow easy and instantaneous extensions to a screen six feet long and five and one-half feet high.

The panels are equipped with removable curtain rods, permitting the use of dainty fabrics for the screen, easily removed and replaced when laundering is necessary.

The provision of all the desirable characteristics of a screen for the sick room, is combined with clever designing to break the rigid lines and angles too often found in a screen.

DOUBLE AND CONDENSER VALVES FOR STERILIZERS

The new double valve has been designed to control accurately the steam input of the sterilizer. With this valve the steam can be regulated merely by turning the valve handle from "off" to "open" until the right temperature has been reached. When the boiling temperature has been reached the valve handle should be turned to "sterilize" to admit enough steam to maintain that temperature. The amount of steam passed is regulated by a needle valve.

The condenser valve, also shown here, may be attached to any utensil or instrument sterilizer having from one and one-half to two-inch standard pipe thread vent opening. It is placed in the vent line and by means of small jets of water condenses the steam and returns it to the general waste line, thus preventing it from escaping into the sterilizing or utility rooms.

These two valves regulate the amount of steam that enters the sterilizing chamber and condense the small quantity of excess steam that would otherwise escape.

"Canada Dry" is served in the great hospitals of Canada and the United States



Always look
for the name
"Canada Dry"
on the bottle
cap to be sure
of the original.



THERE are four important reasons why "Canada Dry" has been given a place in the regimen of great hospitals in Canada and in this country.

"Canada Dry" has a flavor that everybody likes

It is an especially welcome treat in sickness and in convalescence and you will find that it pleases the most particular or irritable patients. They appreciate your serving the same fine ginger ale in the hospital that they buy for themselves at home.

"Canada Dry" is a real Ginger Ale

It is made from the finest Jamaica ginger and it is one ginger ale that does not contain capsicum in any form.

"Canada Dry" has a high CO₂ content

It retains its high carbonization longer than do most ginger ales and its carbonation has a definite therapeutic value.

"Canada Dry" Is Pure

It is bottled in one of the newest and most modern beverage plants in the country and is not touched by hand during any stage of manufacture.

These are important points to remember when you select a ginger ale for your patients.

We will gladly send a sample bottle of "Canada Dry" to hospital superintendents and dietitians.

“CANADA DRY”

Reg. U. S. Pat. Off.

Does Not Contain Capsicum

Extract imported from Canada and bottled in the U. S. A. by Canada Dry Ginger Ale, Incorporated, 25 W. 43rd St., New York, N. Y. In Canada, J. J. McLaughlin Limited, Toronto. Established 1890.

© 1926

Try this dessert for convalescents

CREAM OF WHEAT and Rhubarb Pudding

2 cups cooked Cream of Wheat diced
2 cups rhubarb diced
1 cup sugar
1 tablespoon butter

Into a buttered pudding dish put a layer of cooked Cream of Wheat, then a layer of rhubarb, sprinkle thickly with sugar and keep adding the Cream of Wheat and rhubarb in layers this way until dish is filled, having a thin layer of Cream of Wheat on top. Sprinkle with bits of butter and bake in a slow oven until the rhubarb is thoroughly cooked and the top of the pudding a tempting brown



1. delicious
2. easy to digest
3. economical
4. quickly made

Try this dessert once and you will include it regularly in your weekly menu. It is everything you require in food for your patients—delicious, simple to digest, easy to make and inexpensive.

As you know, physicians approve Cream of Wheat for convalescents and children because it is rich in carbohydrate value and so easy to digest.

Winter or summer, you can always depend on the quality of Cream of Wheat. This is because it is put through a special heat-treatment in manufacture and is protected from all outer contamination by its triple-wrapped-and-sealed box.

You can serve this nourishing food in an endless variety of tempting ways. Send for our recipe booklet, "50 Ways of Serving Cream of Wheat." It's free.

Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

FOR THIRTY YEARS A STANDARD FOOD ON
PHYSICIANS' DIETARY LISTS

© 1926, C. of W. Co.

WATER TUBE BOILER VS. FIRE TUBE BOILER

Not long ago a discussion arose on the subject of boiler explosions. It was held on the one hand that fire tube boiler explosions are more disastrous than water tube boiler explosions since they contain more water per horsepower. On the other hand the contention was that water tube boiler explosions are the more disastrous.

With a view to getting unprejudiced information on the subject inquiry was made of a manufacturer who makes both types of boilers—fire tube and water tube. He replied as follows:

"A return tubular boiler will contain more water per horse power than will a water tube boiler of equal size. For instance, on a 72"x18' boiler, with 70 four-inch tubes and rated at 150 horse power, the weight of the contained water would be 22,800 pounds. On a 150 horse power water tube boiler, having 74 four-inch tubes with one 35-inch drum, the weight of the contained water would be 13,000 pounds.

In other words this manufacturer's fire tube boiler holds nearly twice as much water as does the water tube type.

CORRECT POSTURE CHAIRS

A new health chair adaptable for use in the teaching of the hospital has recently been developed, with the aim of reducing fatigue by placing the body of the occupant in a comfortable and correct posture. The chair is a direct departure from most chairs in that the back gives



Leading pediatricists are recommending Karo (Corn Syrup) for modifying and enriching whole lactic acid milk for infant feeding.

FROM A RECENT REPORT:

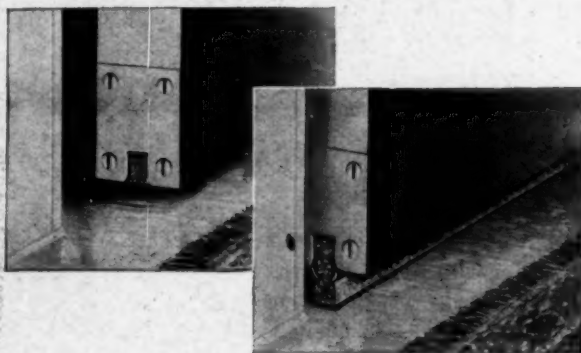
"Recently we have given 6 new-born babies whole lactic acid milk with Karo one ounce to the quart as a complementary feeding when we found the maternal milk supply inadequate after the fourth day, and when we have been unable, by emptying the breast after each nursing by manual expression, to increase the supply sufficiently. They apparently digest this milk with its 3.5 to 4 per cent fat and its 3.5 per cent protein, and do well on it without signs of gastric or intestinal indigestion."



Karo is the Corn Syrup now being prescribed for Infant Feeding—not only because of its High Dextrose content—but because parents can secure Karo from grocers in every village, town and city in every State of the U. S. A.

Prevent

... the spread of odors from
*Operating Rooms ~ Diet
 Kitchens ~ Laboratories*
 with **CHAMBERLIN**
 Inside Door Bottoms



Silent acting, automatic, ingeniously hidden in the bottom of the door, they do not interfere with rugs or mats. A thick but soft piece of felt does the work. 106 Chamberlin Inside Door Bottoms were installed in the new Pasadena Hospital, Pasadena, Calif.

HOSPITAL authorities are agreed on the necessity of Chamberlin Inside Door Bottoms for the modern hospital. These Door Bottoms seal doors so effectively that the odors from operating rooms, laboratories, diet kitchens, etc., are confined where they belong. They also keep the cold night air in rooms and wards from spreading throughout hospital corridors—bar out the under-door draughts that chill the halls and cause general discomfort and increased heating costs. They keep hall noises out of rooms and room noises out of halls, contributing in every part of the hospital that greater degree of quiet so essential to patient welfare. Chamberlin Inside Door Bottoms are also very valuable on doors of dark rooms for developing X-ray photographs. Chamberlin installs these Door Bottoms and guarantees results for the life of the building.

Mail coupon today

CHAMBERLIN METAL WEATHER STRIP CO.
 West Lafayette Blvd., Detroit, Mich.

100 Sales and Service Offices Throughout the United States



Chamberlin Metal Weather Strip Co.
 West Lafayette Blvd., Detroit, Mich.

Please send free copy of your illustrated book.

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Address _____

City _____ State _____ FC-48

support only at the waist line or lumbar curve of the spine, which allows the occupant to sit into the chair in a comfortable position.

The back support can be adjusted both vertically and laterally to give proper support. Because of the flexible manufacture of the product, the base or legs of the chair will adjust themselves to the uneven floor without placing strain on the reaches or stretchers. A feature



adjustment allows raising or lowering the seat so that the occupant's feet may rest flat on the floor. The narrow seat causes no interference with the circulation of the blood in the lower limbs.

The chair is made entirely of steel tubing with the exception of the wood veneer seat, back and tablet arm. The seat and tablet arm are made of five-ply wood veneer and the back of three-ply, although back and seat may be of imitation leather. The chair is also made without the tablet arm.

DATE EACH LAMP

It is almost impossible to know whether electric lamps last as long as they should unless they are tagged or dated. Tags come loose but not so the small stickers on which can be written in ink the date on which the lamps were put into service. With this plan it is possible to estimate the comparative life of various lamps because many of them burn about the same length of time each day. Electric dealers and manufacturers of lamps are always glad to know if their products are not giving as much service as they should. Lamps are supposed to burn about 1,000 hours.

A WAY TO COOL THE KITCHEN

The steward of a Mississippi hospital has found a new way to cool the basement kitchen in his old hospital. At both ends of the kitchen and directly under the electric fans, he has built low pans with a drain tube that empties into a can. In each of these pans is placed a cake of ice, and when the fans are turned on the breeze blows across the ice. This keeps the air in the kitchen cool and moist during the warmest days.



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April, 1926

THE MODERN HOSPITAL

Adv. 83

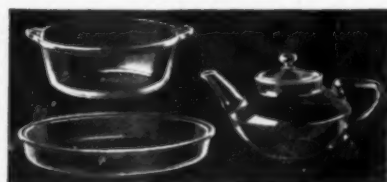
Sterilizing will not crack or break *PYREX* nursing bottles

Reg. U. S. Pat. Off.

Made in 8-oz. size,
in wide mouth and
narrow neck styles



Pyrex Laboratory Ware is standard equipment in leading hospital, scientific and educational laboratories. "Chemists who specify Pyrex will accept nothing else," says a leading distributor.



Pyrex Ovenware is attractive, sanitary and convenient. It permits baking and serving in the same dish—and tests show that it *bakes better*. Food looks more appetizing baked in Pyrex and keeps hot longer.

BECAUSE of their resistance to extreme heat, to sudden changes of temperature, and to breakage from handling, Pyrex Nursing Bottles are particularly adapted to hospital usage.

Repeated sterilizing, sudden cooling, daily and often hurried handling are conditions under which other glassware frequently gives way after very short use. Its breakage is not only a constant source of annoyance, but a considerable item of expense.

Pyrex Nursing Bottles are made to withstand just such usage. Sterilizing—even sudden cooling—will not crack or break them. Tough and resistant to shock, they will be giving dependable service long after other bottles would have been replaced several times.

Pyrex bottles are made in the universally used 8-oz. size, wide mouth and narrow neck shapes.

All Pyrex Nursing Bottles are plainly marked with the trademark "PYREX," and are graduated in ounces and half ounces. They are made hexagonal, to prevent rolling, yet rounded inside to permit easy cleaning.

Special Offer to Hospitals:

Hospitals desiring to test Pyrex Nursing Bottles will be supplied upon request with two bottles free. Please specify whether wide mouth or narrow neck shape is desired.

CORNING GLASS WORKS
Corning, New York

Daylight without Glare

Truscon Donovan
Awning Type
Windows used in
the Receiving Hos-
pital and Nurses
Home, Detroit,
Mich. Carey &
Esselstyn, Archts.
and Engineers.



TRUSCON Donovan Awning Type Steel Windows have many distinctive advantages which make them ideal windows for the up-to-date hospital. Their awning feature, for example, allows full daylighting and unobstructed natural ventilation without sun glare—an important contribution to patient welfare and comfort. These windows are also attractive, durable, and fire safe. They are very easy to operate—a single movement of the lower sash regulating the upper sash as well. Let Truscon Experts assist your hospital board and superintendent in the matter of efficient and economical window equipment.

Write for complete literature.

TRUSCON STEEL COMPANY
YOUNGSTOWN, OHIO

*Warehouses and Offices in All Principal Cities
Foreign Trade Division, New York
The Truscon Laboratories, Detroit, Mich.
Trussed Concrete Steel Co. of Canada, Ltd., Walkerville, Ont.*

***TRUSCON**
DONOVAN
AWNING TYPE WINDOWS

*A complete line of Steel Buildings, Steel Windows, Metal Lath, Steel Joists, Steel Poles, Concrete Reinforcing for Buildings and Roads, Pressed Steel Specialties, Waterproofing & Technical Paints. Truscon maintains Engineering and Warehouse Organizations thruout the Country.

Book Reviews and Current Hospital Literature

TEN YEARS OF SOCIAL WORK AT BOSTON CITY HOSPITAL, OCTOBER, 1925

By GERTRUDE L. FARMER, Director of the Department of Medical Social Work, Boston City Hospital, Boston.

Miss Farmer, in a thirty-eight page booklet, shows very clearly the strides made in the field of medical social work, as she has seen them come in her ten years of experience in a large municipal hospital. She points out the beginnings of the department made possible by far-sighted, thinking, individuals and their pocketbooks. She carries the reader through her demonstration of the value of social service, so that it is made clear why the city is now ready to take over more and more the responsibility for the service it recognizes as an essential part of the care of the sick.

One appreciates that Miss Farmer's department has developed its program largely in the field of need felt by the institution. It is now strengthening its community relationships so that it can better interpret the community's needs to the hospital.

Her booklet is carefully captioned so that the reader can readily find any particular subject he may be interested in. The extramural chart she makes should be particularly interesting as it shows the various factors and influences in a patient's life that the social service worker must bear in mind.

The social work done in the department where children ill with contagious diseases are separated from their natural contacts for very long periods, is brought out by human interest stories demonstrating the substitutes made possible by the social worker in recreation, school work and "second hand messages from home."

The progress made in the more technical side of medical social work is also noted in record writing, teaching of students, nurses, interns, and in case work processes.

The booklet is well worth reading

J. S.

MEMORANDA OF TOXICOLOGY

By MAX TRUMPER, B.S., A.M., Formerly Lecturer on Toxicology, Jefferson Medical College, Philadelphia; with an Introduction by Henry Leffman, A.M., M.D., Emeritus Pathologic Chemist, Jefferson Hospital, Philadelphia.*

The compact handbook on poisons by Dr. Trumper, is a practical treatise based upon Dr. Tanner's book, which is a well arranged compilation of the more important points in toxicology. In this edition is included a large amount of the new views in regard to antidotes and the methods of treatment which are the results of extensive studies in pharmacology and physiologic and pathologic chemistry. The newer sources of poisoning have also been given attention.

*P. Blakistons' Son, Philadelphia.

NOW 3 essentials FROM 1 material

How a remarkable heat-stopping lumber provides beauty, comfort and quiet in modern hospitals—at little or no extra cost.

Harsh, glaring walls produce a feeling of coldness and depression in visitors and patients alike.

In hospitals, especially, architects and decorators have long been seeking a soft, textured wall finish like that in the reception room shown here. This pleasing effect was secured with Celotex Insulating Lumber. On the walls, Celotex has been left in its natural finish. The ceiling shows its decorative possibilities when stained or painted. Celotex may also be enameled or covered with any suitable fabric.

Stops heat and cold—saves fuel

Celotex is a special lumber made from cane fibre. It is made to stop heat—to shut out wind and moisture—to deaden sound.

Thus it will provide the protection so necessary to your convalescents against draughts, sudden temperature changes and noises.

As sheathing, Celotex replaces wood lumber under brick, stucco or wood exteriors. It also takes the place of lath on inside walls and ceilings where plaster is applied to its surface.

The proper use of Celotex keeps out

heat in summer and cold in winter. It strengthens the building, cuts repair costs, reduces heating cost about $\frac{1}{3}$.

The use of Celotex costs little or nothing extra, and is practical in old and new buildings alike.

For quieting noise

A special form of Celotex—Acousti-Celotex—is used on corridor ceilings to quiet noise. This type of Celotex is a highly efficient sound-absorbing material as well as an insulator. It is useful in quieting noise in delivery rooms, nurseries, elevator lobbies, serving kitchens and many other places.

A free service to hospitals

The expert engineers of our Acoustical and Service Departments will cooperate in working out the proper uses of Celotex in your institution. Their services are free and will not obligate you in any way.

Also ask your architect, consultant, contractor or lumber dealer to tell you more about Celotex. All lumber dealers can supply it. Building authorities advise its use in modern hospitals.

Mail coupon for free booklets describing its uses and advantages.

THE CELOTEX COMPANY, CHICAGO, ILLINOIS
Mfrs: New Orleans, La.

Branch Sales Offices in many cities—(See telephone books for addresses)
Canadian Representative: Alexander Murray & Co., Limited
Montreal, Toronto, Halifax, Winnipeg, Vancouver

CELOTEX

INSULATING LUMBER

THE CELOTEX COMPANY, Dept. T-284
645 N. Michigan Avenue, Chicago, Ill.

Please send more information about Celotex Insulating Lumber and Acousti-Celotex.

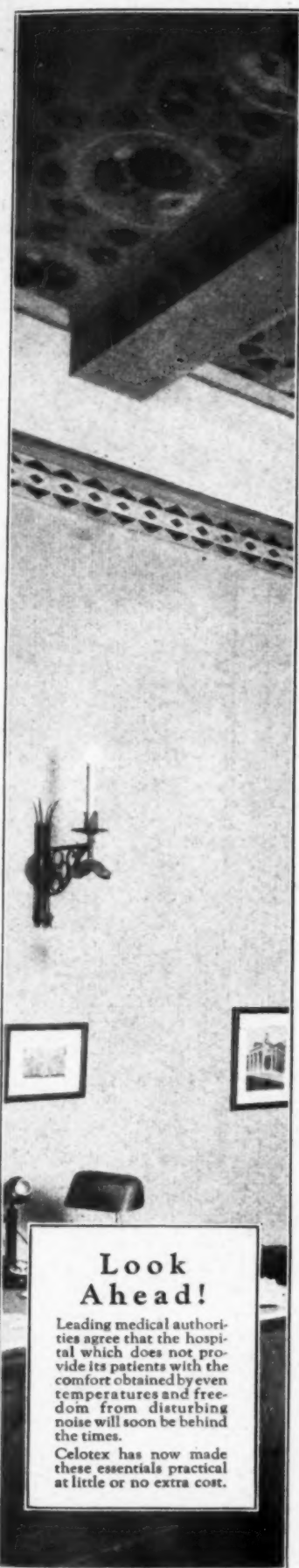
Name.....

Hospital.....

City..... State.....

Mod. Hosp. 4-26

For complete index of advertisements refer to the Classified Directory



Look Ahead!

Leading medical authorities agree that the hospital which does not provide its patients with the comfort obtained by even temperatures and freedom from disturbing noise will soon be behind the times.

Celotex has now made these essentials practical at little or no extra cost.

NEWS OF THE HOSPITALS AND SANATORIUMS

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

Arizona

Assure Veterans' Tuberculosis Hospital at Tucson.—Tucson has been placed on the priority list by the hospitalization board of the U. S. Veterans' Bureau and an \$850,000 hospital will be erected for tuberculosis patients.

Change Administration at Otisville Municipal Sanatorium.—The Municipal Sanatorium, Otisville, which previously has been under the control of the bureau of general administration, has been placed under the jurisdiction of the bureau of hospitals. Dr. T. F. Joyce has been retained as medical superintendent.

California

Hospital Plans Doctors' Office Building.—With the issuance of a \$225,000 building permit, the hospital association of St. Francis Hospital, San Francisco, took definite steps to provide office facilities for physicians in the vicinity of the hospital.

Open First Unit of California Lutheran Hospital.—The formal opening of the first unit of the new \$1,750,000 California Lutheran Hospital, Los Angeles, occurred early in March. The nine-story hospital structure contains nine operating rooms and has facilities for 275 patients. It is the first vertical service hospital to be built in the state.

Hospital Head Dies of Sleeping Sickness.—George B. Somers, physician-manager of the Stanford Hospital, Palo Alto, died February 21, following an attack of sleeping sickness of two weeks' duration. Dr. Somers was also professor of gynecology at Stanford University medical school.

Dr. Thomas O. Burger has been elected president of the staff of Mercer Hospital, San Diego, for the ensuing year.

Colorado

Dr. E. J. Brady, manager, has announced that a sixteen-room addition of the Colorado Springs Psychopathic Hospital, Colorado Springs, to the men's dormitory will soon be completed. This will bring the capacity up to fifty-five beds.

Connecticut

Dr. Chester E. Haberlin has been appointed on the staff of the Emergency Hospital, Bridgeport.

Superintendent Given Leave of Absence.—Kathryn M. Prindeville, who has been superintendent of Lawrence and Memorial Associated Hospitals, New London, and its school of nursing, for the past fourteen years, was recently allowed a six months' leave of absence. Miss Prindeville left during early February for an extended Mediterranean cruise.

District of Columbia

Ask Removal of Walter Reed Hospital.—The streets and avenues committee of the Washington Board of Trade asked that the Walter Reed General Hospital be removed to an outlying section of the city if its present location prevented the extension of Fourteenth street. It was pointed out that by the sale of the present hospital building and site enough money to purchase several times as much ground in the suburbs would be realized.

Florida

George E. Sebring, Sr., recently offered to donate \$10,000 toward a fund to erect a \$150,000 hospital in Sebring, provided enough other citizens are willing to subscribe funds.

Walker Appointed County Hospital Head.—Fred M. Walker, Alliance, Ohio, was recently appointed superintendent of the new \$500,000 county hospital, Jacksonville. Mr. Walker was superintendent of the City Hospital, Alliance, for three years, and was stationed at the Walter Reed General Hospital, Washington, D. C., during the war.

Georgia

Rev. W. A. Jonnard, general chairman of the Kiwanis committee officiated at the ceremonies attending the ground breaking for the construction of a new Kiwanis fresh air unit, Savannah.

Illinois

Dr. Karl L. Thorsgaard has been elected chief of staff at the American Hospital, Chicago.

Alexian Brothers Pass Sixtieth Anniversary.—In celebrating the sixtieth anniversary of the initial activity of the Alexian Brothers in Chicago, a report of the hospital's activities states that 40,000 patients have been treated free during this period. The order has owned four hospital buildings, the first of which was a temporary hospital. The second building, built in 1868, was destroyed in the Chicago fire of 1871. The present structure, which has a capacity of 300 beds, houses all of the mechanical departments.

May D. Collins was recently named superintendent of the Victory Memorial Hospital, Waukegan. Rev. W. Gangster was elected president of the board of directors.

REMOVAL ANNOUNCEMENT

WARD, WELLS, DRESHMAN & GATES

ORIGINATORS OF THE INTENSIVE PLAN—THE MODERN SCIENTIFIC METHOD
OF RAISING FUNDS FOR HOSPITALS AND OTHER PHILANTHROPIC
INSTITUTIONS

ON ACCOUNT OF INCREASE OF BUSINESS DEMANDING MORE ROOM
WILL MOVE THEIR NEW YORK OFFICES ABOUT APRIL 20 TO THE NEW



FARMERS LOAN & TRUST COMPANY BUILDING,
475 FIFTH AVENUE
COR. 41ST ST.

Overlooking The Public Library and Bryant Park, where Old Friends and
New will be Cordially Welcome.

IT WILL COST YOU NOTHING TO CONFER WITH US ABOUT YOUR FINANCIAL
PROBLEMS

OUR QUARTERLY BULLETIN "FINANCING SOCIAL PROGRESS" WILL BE SENT
UPON REQUEST

WARD, WELLS, DRESHMAN AND GATES
Metropolitan Tower, New York 612 Wrigley Bldg., Chicago



Send for This Booklet—Now!

MANY Hospitals and similar public institutions which have experienced great difficulty in securing financial support for the solution of their building and maintenance problems, have realized their fondest hopes through the engagement of the Ehler Financial Campaign service.

What Ehler service has done for others—how effectively it operates in the face of seemingly insurmountable obstacles—the indelible stamp of public approval and civic pride that it leaves behind—these are intimately discussed in our latest booklet "Success in Raising Money." Send for your copy today. Your request involves no obligation.

Herbert B. Ehler & Co., Inc.
15 Park Row, New York, N. Y.

Dedicate University of Illinois Student Hospital.—The new \$200,000 hospital, donated by Senator William B. McKinley, Champaign, for the care of students at the University of Illinois, Urbana, was dedicated, February 13. It conforms to the style of architecture of other campus buildings, and is located in the University of Illinois Forestry at the west end of Indiana Avenue, Urbana.

Dr. Arthur J. Fletcher was recently re-elected president of the staff of St. Elizabeth's Hospital, Danville. Edward J. Wheatley was also named vice president and Dr. George T. Cass, secretary.

Dr. Llewellyn C. Merrill, former superintendent of the Illinois General Hospital, Chicago, died of heart failure recently.

Million-Dollar Hospital for Chicago's South Side.—According to plans made public by Dr. A. M. Moore, president, the new \$1,000,000 Alpine Hospital, Chicago, will be ready for occupancy early in 1927. The hospital, when completed, will provide facilities for 805 patients, with forty-five private rooms. An open-air roof garden will be one of the features of the seven-story structure.

Students Join University of Illinois Hospital Association.—Although 3,728 students at the University of Illinois, Urbana, had joined the University Hospital Association during the first week of the membership campaign, the total membership was less than at the end of the first week in the first semester of the school year. Membership in the association allows the student or faculty member a two weeks' period of hospitalization during the semester without hospital charges.

Indiana

Ball Brothers Donate Funds for Hospitals.—Frank E. Ball, George A. Ball and Dr. Lucius L. Ball, Muncie, recently gave \$1,000,000 to the city of Muncie for the erection and endowment of a general hospital and nurses' home to be known as the Ball Memorial Hospital. The James Whitcomb Riley Hospital, Indianapolis, also profited to the extent of \$500,000 for the erection of a training school and home for nurses, providing people of Indiana raise \$1,000,000 for the same purpose.

Lay Cornerstone for New Surgical Unit.—The cornerstone for the new \$385,000 surgical unit of the City Hospital, Indianapolis, was recently laid, with appropriate ceremonies.

Donate \$20,000 for Clinical and Research Laboratory.—The Indianapolis Foundation recently gave Sunnyside Sanatorium, the Marion County tuberculosis sanatorium, Oaklandon, \$20,000 for the equipment and maintenance of a clinical and research laboratory, for a period of two years. One-half of this fund is to be spent the first year, the remainder being spent the second year. In addition to the routine laboratory work of the institution, research in tuberculosis will be carried on, in collaboration with the research council of the National Tuberculosis Association.

Iowa

R. A. Bates has been chosen as superintendent of St. Luke's Methodist Hospital, Cedar Rapids.

Dr. Bundy Allen, x-ray and radium specialist at the University of Iowa, recently resigned in order to take the position of roentgenologist at a \$2,500,000 private hospital now being built in Tampa, Fla.

Merger of Iowa City Hospitals.—The Iowa Lutheran Hospital and the Iowa Congregational Hospital, Des Moines, have recently concluded arrangements for merging the two institutions. The latter institution will be maintained as a branch.

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Kansas

Open Osteopathic Sanitarium at Wichita.—The Southwestern Osteopathic Sanitarium, Wichita, was formally opened February 6. The sanitarium includes the main hospital building and the nurses' home, erected and equipped at a total cost of \$200,000.

Kentucky

Good Samaritan Secures New Superintendent.—Lake Johnson, formerly in charge of St. Mary's Hospital, Athens, Ga., was recently selected as superintendent of the Good Samaritan Hospital, Lexington, succeeding Alberta Dozier. Miss Johnson was formerly connected with the nursing staff of the General Hospital, Kansas City, Mo.

Louisiana

Plan Construction of Three Units.—The Soniat Memorial Hospital, New Orleans, has asked for bids for the construction of a fifty-bed addition on Annunciation Street, which will be the first of three additions to the hospital, with a total expenditure of \$1,225,000.

Maryland

File Plans for Union Memorial Addition.—The plans for the new nurses' home and Children's Hospital of the Union Memorial Hospital group, Baltimore, were recently filed at the bureau of buildings. The contract has already been awarded for the \$600,000 structure, which will be known as the Johnson Memorial Building. The building will be the second of three units in the group.

Minnesota

Plan Addition to Shriners' Children's Hospital.—According to plans made at a recent meeting of Shriners at Minneapolis, a new \$250,000 convalescent home for crippled children will be added to the present Shriners' Hospital, Minneapolis.

Mississippi

Julia Dainwood was recently named as superintendent of the Mississippi Baptist Hospital, Jackson.

Missouri

Louise Hilligrass has been retained by the University Hospital, Columbus, as superintendent.

Plan Hospital in St. Louis Medical Building.—According to plans which were recently made public, a ten-story office building, to be occupied exclusively by physicians and dentists of St. Louis, will include a small hospital and x-ray and pathological laboratories. The hospital and some of the laboratories will be on the tenth floor of the structure. The hospital will be used only for emergency treatments, examinations requiring not more than twenty-four to forty-eight hours, and minor operations resulting in confinement of a like period. Tenants will be charged an established fee for the use of the hospital and the laboratories.

Montana

U. S. Army Reserve Hospital at Billings.—General Hospital No. 145, U. S. Army Reserve, has been allocated to the state of Montana with headquarters at Billings, St. Vincent's Hospital acting as sponsor. Dr. William R. Morrison, Billings, has been designated commander of the reserve hospital with the rank of colonel.

Nebraska

Plans Authorized for Omaha Hospital.—The plans for the new wing of the Nebraska Methodist Episcopal Hos-



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pital, Omaha, to be erected at a cost of \$350,000, have been accepted by the members of the board of directors of the hospital. The new wing will provide quarters for 100 nurses and will also include a cancer ward, as requested in the will of the late Belle Dewey, who left a large sum of money to the hospital.

St. Joseph's Opens Addition to Public.—Dedication ceremonies marking the completion of the addition to St. Joseph's Hospital, Alliance, were held February 11 when the new wing was thrown open to the public, according to Mother Teresa, superintendent.

New Jersey

Dr. Earl Snively, medical director, Newark City Hospital, Newark, was in charge of the ceremonies when the new Convalescent Hospital, Ivy Hill, South Orange, opened recently. The new structure will accommodate 100 patients.

Laura McKindless, who has been superintendent of the Paul Kimball Hospital, Lakewood, for the past seven years, recently resigned that position. As yet no successor has been appointed.

Break Ground for Hospital Annex.—Ground was broken in the yard of the Cooper Hospital, Camden, recently for the construction of a four-story annex which is made possible through a donation from S. C. Childs, West Collingswood.

New Mexico

Plan War Mothers' Memorial at Albuquerque.—The local committee of the War Mothers' Memorial Association was recently informed that Albuquerque has been selected as the site of a \$7,000,000 hospital and farm colony for tubercular patients. The formal selection will be made by a special committee appointed for that purpose.

New York

Maude W. Woolsey, former superintendent, Highland Hospital, Beacon, died recently in Grantwood. Miss Woolsey served in France as a special ambulance nurse and more recently was engaged in Red Cross and settlement work in New York.

Dr. Ezra Bridge, superintendent, Stony Wold Tuberculosis Sanatorium, Lake Kashaqua, has been offered the position of medical supervisor of the Monroe County Tuberculosis Sanatorium, Rochester, to succeed Dr. John J. Lloyd, resigned.

Chester H. Lang was elected a member of the board of managers of the Ellis Hospital, Schenectady, at its recent annual meeting, to fill the vacancy caused by the death of Joseph W. Smitley.

Dr. H. S. Shumacher was appointed president of the staff of the Rochester Homeopathic Hospital, Rochester, at the annual meeting of the board of governors. Announcement was also made of the planned opening of the new pavilion during the late summer. This pavilion will make possible a large increase in the work of the hospital's out-patient and children's departments.

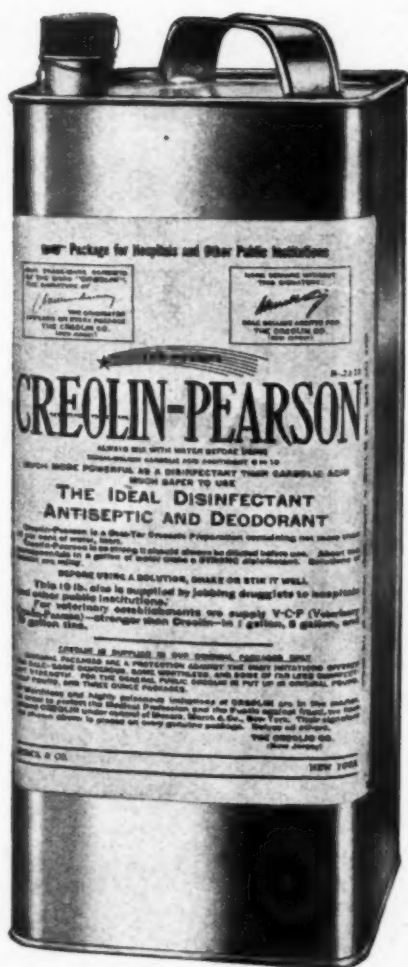
Veterans' Hospital on Long Island.—The Hodgens estate at East Northport, L. I., comprising 550 acres, was recently purchased by the U. S. Veterans' Bureau for the purpose of establishing a neuropsychiatric hospital for World War veterans. The institution is planned to accommodate 1,000 patients and will be erected at an approximate cost of \$3,000,000.

Miss Goldsmith on Trip Around World.—Miss Frances M. Goldsmith, graduate nurse of Mount Sinai Hospital, New York, sailed on January 20, on a trip around the world, and plans to visit many foreign hospitals.

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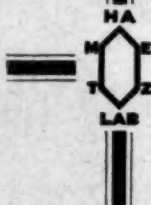
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Brooklyn Jewish Hospital Completes Campaign.—At a dinner held January 16, subscriptions amounting to \$250,000 were received, completing a fund of \$1,500,000, which insures the erection of a new wing and other additions to the Brooklyn Jewish Hospital, Brooklyn.

Italian Medical Society Plans Hospital.—The Italian Medical Society, Brooklyn, gave a dinner, February 8, at the Hotel Bossert, in an attempt to raise \$300,000 for a local Italian hospital. Another fund of \$100,000 was also started to equip the main building.

Arthur L. Lee, managing director of the Hotel McAlpin, New York, was recently elected president of the Jamaica Hospital, Jamaica, to succeed William C. Reid, resigned. The present hospital building was erected and equipped under his direction as chairman of the supervising committee.

Fleming Named Bellevue General Superintendent.—Dr. Mark L. Fleming recently became general superintendent of Bellevue Hospital, New York, after acting in that capacity since October when the former general superintendent, George O'Hanlon, resigned. Dr. Fleming has been connected with the hospital for twenty years.

Remove Patients Safely When Hospital Burns.—All of the patients were moved in safety to other hospitals when the Kingston City Hospital, Kingston, was destroyed by fire recently, at a loss of \$100,000.

Dr. Edward H. Peaslee, who was recently re-elected president of the New York Nursery and Child's Hospital, New York, has announced that the hospital expended more than \$150,000 last year in providing free care to mothers and babies of Manhattan. During the year 2,243 babies were born at the hospital.

North Carolina

Named Rex Hospital Superintendent.—Virginia Marshbanks has been appointed superintendent of Rex Hospital, Raleigh.

Jessie Allen Goes to Kingston City Hospital.—Jessie Allen, New York, was recently engaged by the board of directors of the Kingston City Hospital as directress of nurses at that institution, succeeding Martha Morningstar, who resigned to accept a position at St. Luke's Hospital, Newburgh.

North Dakota

Open Fargo Hospital Addition.—The formal opening of St. John's Hospital, Fargo, was held March 1. The lack of adequate facilities which has handicapped the work of the institution for the past eight years will be greatly alleviated with the \$325,000 addition.

Ohio

Dr. Alfred F. Hess, professor of pediatrics in the Physicians and Surgeons College of Columbia University, New York, recently dedicated the amphitheatre of the new Babies' and Children's Hospital, Cleveland, which will be used for clinics of the senior and junior medical students of Western Reserve University.

Resigns as Hospital Association President.—W. H. Spencer-Strong recently resigned as president of the Good Samaritan Hospital Association, Sandusky.

Dr. Urban D. Siedel has been elected chief of staff for 1926 for the Children's Hospital, Akron.

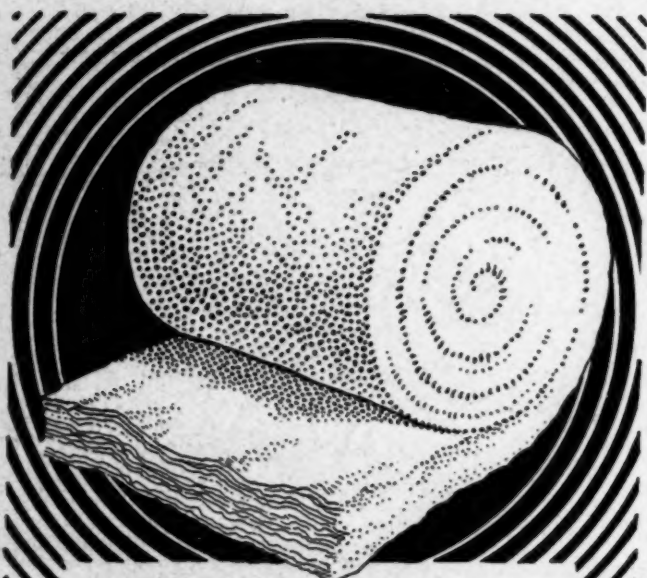
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Oklahoma

Helen Wark Replaces Katherine Rawson as Superintendent.—Helen Wark, Kansas City, was named as superintendent of the Washington County Memorial Hospital, Bartlesville, to succeed Katherine Rawson, who recently resigned. Miss Wark will also act as the superintendent of nurses at the hospital.

Dr. David D. Paulus, Oklahoma City, has been appointed superintendent of the Oklahoma City Clinic and Wesley Hospital, to succeed George D. Hansen, resigned.

Pennsylvania

John M. Smith, director, Hahnemann Hospital and president of the Hospital Association of Philadelphia, recently announced that 132 interns have been appointed to Philadelphia hospitals for from one to two years. The hospitals to which they will be assigned are the Lankenau, Chester County, Women's Homeopathic, Methodist Episcopal, Howard, Children's Homeopathic, Germantown, Pennsylvania, Abington Memorial, University of Pennsylvania Hospital, Jefferson, Hahnemann, Jewish, Chestnut Hill, Episcopal and Mount Sinai Hospitals.

New Spencer Hospital at Meadville Opened.—The new hospital building of the Spencer Hospital, Meadville, which replaces the old building partially destroyed in a recent fire, has been opened to the public. The old building has been remodeled into a nurses' home.

Dr. Leo W. Hornick, Johnstown, has been elected president of the staff at Mercy Hospital, Johnstown.

Dr. S. S. Goldwater, New York, has been retained as consultant to the Bryn Mawr Hospital, Bryn Mawr, in preparing plans for the reconstruction of the entire hospital and its gradual expansion to 500 beds. The new hospital will occupy the site of the present building.

Dr. G. Walter Zulauf, superintendent, Allegheny General Hospital, Pittsburgh, is collaborating with Dr. S. S. Goldwater, New York, in preparing plans for a new hospital of 500 beds, one-half of which will be devoted to wards. The present buildings, less than twenty years old, have been found to be inadequate, although having a capacity of 400 beds.

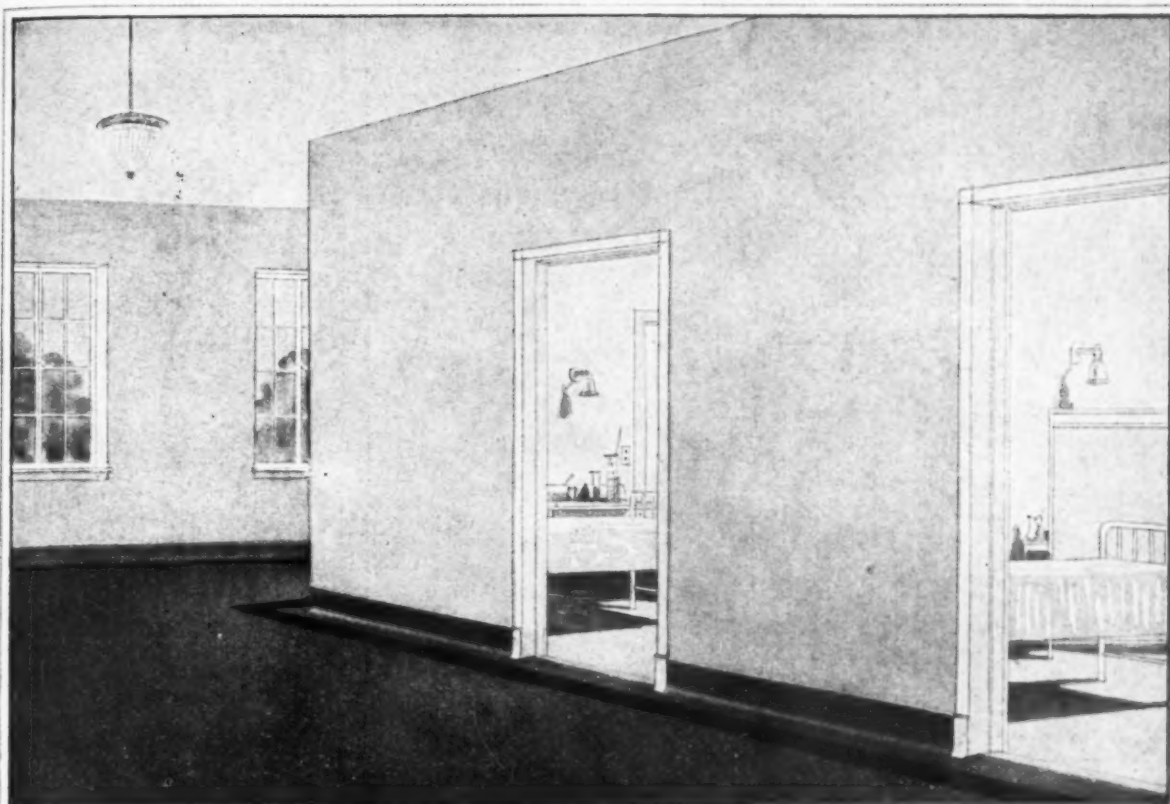
Personnel Changes at Chambersburg Hospital.—Following the resignation of Dr. J. H. Mayer, superintendent, Chambersburg Hospital, Chambersburg, T. C. McDowell was elected head of that institution at a recent meeting of the board of directors. Mary Rhodes, who has been head nurse, was advanced to the position of directress of nurses.

Dr. Allen B. Dalton, Chester, has been appointed chief resident at the Harrisburg Hospital, Harrisburg. He began his duties at the institution March 1.

Hospital Purchases Ground Plot.—The officials of the Pittstown Hospital Association recently announced the purchase of seventeen lots from the Laura Gannon estate, Oregon Heights, adjoining the hospital property. The property was added with the intention of beautifying the hospital surroundings.

Dr. Leckie Named Superintendent.—Dr. John W. Leckie, Hazelton, has been appointed medical director of the new \$450,000 West Mountain Sanatorium, Scranton, which was recently opened.

Maloney Donates \$250,000 for Memorial Clinic.—Martin Maloney, Scranton, recently donated \$250,000 to be used as the nucleus of a fund for the erection within three years of a new \$750,000 building for the medical division of the Hospital of the University of Pennsylvania, Philadelphia. The building, when erected, will be known as the Martin Maloney Memorial Clinic.



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South Carolina

Rock Hill Hospital Burns.—The Summer Hospital, Rock Hill, was recently damaged to the extent of \$15,000 by a fire of unknown origin. Although most of the equipment was saved, the building was a total loss. There were no casualties.

South Dakota

T. W. Dwight was recently elected president of the board of directors of the Sioux Valley Hospital Association, members of which are from various Protestant churches of Sioux Falls, who are endeavoring to secure a modern hospital for the city.

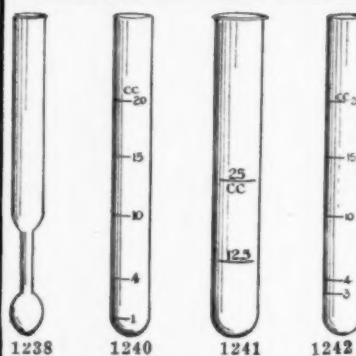
Mollie Lowery, Wesson, has been appointed superintendent of nurses at the Charity Hospital, Jackson, and Birdie Lee has been named night superintendent.

Tennessee

Sheats Re-elected as Baptist Memorial Head.—George D. Sheats, superintendent of the Baptist Memorial Hospital, Memphis, for the past two years, was reelected for another twelve months at a meeting held recently by the executive committee of the hospital.

Plan \$100,000 Hospital at Murfreesboro.—Plans and specifications for a forty-eight bed hospital at Murfreesboro, to be erected with a \$100,000 fund secured from the Commonwealth Fund of New York, have been received from the architects, and contracts will be let. The site for the hospital has been selected and arrangements have been made to have the city and county support and maintain the hospital for a period of five years.

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